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REPORT AND RECOMMENDATIONS

Of The

MONTANA COMMITTEE ON THE PROBLEMS OF THE AGING

For The White House Conference On The Aging

Helena, Montana

August 6, 1960

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THE FOLLOWING REPORT IS RESPECTFULLY SUBMITTED TO

THE HONORABLE J. HUGO ARONSON, GOVERNOR OF MONTANA

AND

TO THE DELEGATES TO THE WHITE HOUSE CONFERENCE ON THE AGING

Chairman

This, the final report and recommendations of the Montana Committee on the Problems of the Aging, represents a composite effort on the part of the members of the Montana Committee. In fact, the entire program of study and research in the field of the problems of the aging was undertaken and conducted by all of the members of the Committee.

True, as is the case in any such Committee, certain members of the Committee were able, by reason of time and circumstance, to devote more attention to and take a more active part in the work done by the Committee. But this, it would seem to us, is a rather normal situation.

Insofar as this report is concerned, we feel that special acknowledgement should be made for the part played in the drafting and assembling of the report and recommendations by the following individuals:

Dr. James A. Shown, Chairman
Committee on Aging, Montana Medical Association
Great Falls

Dr. Jess Schwidde
Billings

Dr. Robert Spratt, Superintendent
Montana State Hospital
Warm Springs

Mr. Louis W. Wurl
Montana State Hospital
Warm Springs

Mr. Lewis G. Lansing
Montana Employment Service
Helena

Mr. Glenn O. Lockwood, State Director
Bureau of Vocational Rehabilitation
Helena

Mr. Vivian Burr
State Department of Public Welfare
Helena

Dr. E. O. Bratsberg
Kalispell

Dr. E. A. Atkinson
Director of Summer Session
Montana State University
Missoula

Mrs. Don McLaughlin
Butte

Mr. O. A. Bergeson
Dillon

All of the above-named individuals were very active members of the Montana Committee on the Problems of the Aging. In additon, much of the work of the compilation of this final report and recommendations fell to the lot of the Vice-Chairman and Secretary, Mr. Francis A. Howard of Helena.

The Montana Committee on the Problems of the Aging was originally appointed by the Honorable J. Hugo Aronson, Governor of Montana, in the late spring of 1959. Committee personnel were appointed from many sections of the State and the Committee consisted of the following individuals:

Ralph C. Knoblock, Helena, Chairman

Francis A. Howard, Helena, Vice-Chairman and Secretary

Dr. James A. Shown, Great Falls

Mr. Lewis G. Lansing, Helena

Mr. Glenn O. Lockwood, Helena

Mr. Vivian Burr, Helena

Dr. Robert J. Spratt, Warm Springs

Mr. O. A. Bergeson, Dillon

Dr. E. O. Bratsberg, Kalispell

Mrs. Don McLaughlin, Butte

Mr. L. A. Christenson, Cut Bank

Mr. Louis W. Wurl, Warm Springs

Rt. Rev. Msgr. D. B. Harrington, Helena

Dr. Jess T. Schwidde

Dr. E. A. Atkinson, Missoula

Dr. David T. Berg, Helena

Mr. Richard Lubben, Bozeman

R. B. Richardson, Helena
(Ex-Officio Chairman)

Mrs. Gladys Knowles, Billings
Mrs. Dallas Reed, Missoula
Members of the National Advisory Council

The Montana Committee on the Problems of the Aging held its first organizational meeting in the summer of 1959, and, at this first meeting, endeavored to establish some foundation on which the Committee could build a practical, worthwhile and meaningful program for research and study. It was determined at this first meeting that if problems of the aging did, in fact, exist within the borders of the State of Montana, then we should logically endeavor to find out what those problems were.

Further, if there were no problems in existence then it was decided we should make a determination as to whether or not problems could be expected to develop within a period of a few years.

And, finally, if problems did exist within our own State borders and if it were possible for the Committee to pin-point those problems, then we should endeavor to work toward solutions.

While it might be expected that the degree of seriousness of problems of the aging in a state like Montana might be less than that in other states, no one on the Committee was so naive as to expect that the problems, if any, offered little challenge. Certainly, in a state covering thousands of square miles—in fact, prior to the admittance of Alaska to the union of states, Montana was the third largest state in the country area-wise--and with a very, very sparse population of approximately 660,000 people, living in an economy almost totally rural, we anticipated that those problems of the aging which did exist certainly would not

necessarily tax our ingenuity or our ability to find solutions. On the other hand, the Committee realized that while our problems, if any, were less serious than those states with greater populations and more metropolitan areas, we could do a better job if we were to limit our activity to a relatively small number of areas identified with the problem.

The White House Conference on the Aging had found approximately 20 areas of study in which aging committees or commissions could expend their energies. We, in Montana, preferred to confine our study and research to those specific areas where we felt we could accomplish something concrete and worthwhile. Hence, the study made by the Montana Committee was limited solely to the following areas:

General health

Mental health

Rehabilitation

Employment

Housing

Education

Recreation

Having established the foregoing basic premise and having determinded specific areas of study we then proceeded as a Committee to start our program. We soon learn'd that the desire to start the program and our being able to get underway with the project were two different things. We, frankly, made little, if any, progress. As a Committee, and individually as members, we developed a feeling of frustration, which was due, no doubt, to the fact that even by limiting our activity to seven specific areas we found that the problem was so broad and nebulous that we could not grasp specifics in our efforts to make progress.

While we in Montana like to think that we operated under extreme difficulties from a distance, terrain and climate standpoint, we should be honest enough to admit that our problems in getting together as a Committee were no greater than

those of the committees and commissions in certain other states.

Climate extremes in Montana, mountainous terrain, and vast distances between cities all appeared to be effective in creating difficulty for the Committee members to get together at very frequent intervals. On those occasions when we could get together, we found ourselves faced with our apparent inability to pinpoint our task.

It was at this time and at this point that the Committee made the decision to allocate as much of the work of research as possible to local communities. This would accomplish a two-fold purpose: it would give us the benefit of surveys of existing facilities at the local level, thus insuring a higher degree of accuracy in order for us to learn what presently was being done for the aged in Montana, and, secondly, we knew that it would bring forth opinions of local citizens which would be "grass roots"opinions. Certainly, by bringing many, many Montanas into contact with the State Committee, we would be able to identify more and more people in the State with the problems of the aging and give us something more concrete and specific on which to work. While this did not occur to us at the time, we actually were embarking on a project which, while very worthwhile, was tremendous in scope. The Committee, frankly, had no idea of the voluminous amount of time and effort which would necessarily be expended in appointing and activating local groups to delve into the problems of the aging.

Montana has 56 counties; efforts were made to appoint a local subcommittee in each of the 56 counties. The initial approach was made with the assistance and guidance of the State of Montana Department of Welfare through its local county welfare department supervisors. In a state as sparsely populated as Montana, some welfare department supervisors supervised, in some cases, two counties and in one or two instances, three counties. These welfare departments' supervisors were asked to furnish names of local citizens to whom letters of invitation to serve on

be sent. After many weeks of voluminous correspon-

dence and painstaking effort, subcommittees were appointed and in most instances were actively functioning in approximately forty counties out of Montana's 56 counties.

Each member of each county subcommittee was then furnished with statistics, unearthed by the Montana Committee, with reference to the total population of the State of Montana in 1950 and 1959, the number of individuals in the State 65 years of age and over, (both of the foregoing figures based on the 1950 census and the approximate count in 1960,) etc. In addition, statistics furnished included the number of individuals 65 years of age and over receiving old age assistance, number receiving old age and survivors insurance, number receiving OAA and OASI benefits, total number in the state hospital, total number in special-care facilities, nursing homes, etc., number in the Montana Home for the Aged in Lewistown, Montana, the number in other state homes, etc.; included in the statistics furnished were figures on the number receiving unemployment insurance by age brackets together with statistics on employment of older workers, again by age brackets. During a given week a survey was made of all hospitals in Montana so that a determination could be made as to the number of individuals age 65 or over who were hospital-confined during a given week with a detailed breakdown as to the basis on which such individuals were admitted to the hospital. And finally, complete statistics by counties as to the 1950 census, the estimated 1958 population, the percentage increase, the number 65 and older in 1950, the estimated number 65 and over in 1959, and the percentage increase.

All of the foregoing statistics which were furnished to the members of the local Montana county subcommittees appear as a part of this report.

As an added incentive to the local county subcommittees to start their research and study, the Montana State Committee furnished to each of the members of such subcommittees, questionnaire survey forms having to do with housing, em-

ployment, economic needs, community needs, general and mental health, rehabilitation, and education. It was hoped by the Montana Committee that by furnishing such survey questionnaire forms we would be giving the subcommittees a track on which to run and would be, in turn, giving them something concrete, which they could grasp, so that their research and study could begin.

Admittedly, our survey questionnaire forms were admirably suited, in many instances, to some sections of the State and very poorly suited to other sections. This resulted in something which turned out to be advantageous in that many county subcommittees used the Montana Committee's survey questionnaire forms as a basis for their own type of questionnaires which they drew up and which more nearly suited their local situation.

This, then, was the solution to the first problem which confronted the Montana Committee—namely to successfully initiate a concrete and practical program in the State. But, if we were to expect local citizens to take an active interest in our efforts to determine what problems of the aging existed in the State and what solutions, if any, could be reached, then, we had to find some other means of making these local citizens an integral part of the overall State program. Certainly, if the State Committee had merely asked these local citizens to compile a report and send it in to the State Committee we would have had little, if any, cooperation and rightly so.

Therefore, the Montana Committee embarked on its third project encompassing the holding of regional conferences on the aging throughout the State. Why did we feel that Regional Conferences were necessary? Our reasons can be listed as follows:

1. We thought it best to find out what facilities presently existed for the aged and what services were presently being performed for the aged on the <u>local level</u>. Statistics furnished by a state department, while informative, are not necessarily correct in all instances. Through Regional Conferences we could get

first-hand information from the local citizens concerning what was presently being done for the aging population in the particular region.

2. We felt, as a Committee, that the members of the local subcommittees should have some local recognition for the job which they had done on a voluntary basis and we wanted to give these local citizens an opportunity to appear before their fellow citizens so that they could express their opinions, state their views, and make their recommendations, if any.

3. As a Committee, we had already determined that for the most part problems of the aging as they existed in Montana could probably best be solved at the local level and while we, as a Committee, might not come up with any solutions to the problems which we uncovered, we could accomplish a tremendous amount of good if we could make the local communities aware of the fact that the problems of the aging were, in effect, both a responsibility and an opportunity for the local community. Therefore, the Regional Conference helped to bring about this objective.

4. By holding Regional Conferences we could, through proper program planning, arrange to have retirees appear on the program so that we, as a Committee, could find out first-hand exactly what these senior citizens wanted done or, for that matter, not done.

5. By holding Regional Conferences, the State Committee could, finally, prepare for and plan a State Conference on the Aging on a much more intelligent and practical basis; we would have the benefit of the experience of the Regional Conferences and a vital local background for what would result in our final report and recommendations.

Therefore, Regional Conferences were planned as follows:

Glasgow - April 5, 1960

Miles City - April 7, 1960

Billings - April 13, 1960

Great Falls - April 21, 1960

Missoula - April 26, 1960

Butte - April 28, 1960

In planning our six Regional Conferences, we attempted to lay a proper foundation in each of the six regions, namely, that the conferences were not being held for the aged citizens, but rather were being held for all citizens of all ages. We did not feel it proper that our problems of aging be identified solely with aged people. It is accepted fact that our problems of the aging, while acute, to a degree, in this year of 1960, are not nearly as acute as they will become during the next ten to fifteen years.

Therefore, as a proper keynote for the six Regional Conferences we attempted to build our programs around the fact that the young-age group and the middle-age group are the ones needing the most indoctrination to the problems of the aging.

We did not ignore the retirees, by any means. Such individuals were, when such could be arranged, invited to be active participants on the program. The format of the programs in the six regions was something as follow:

1. A general statement of the problems in the region and introductory remarks by the local regional program chairman.

2. A general statement by a member of the State Committee as to the responsibilities and objectives of the Committee as a coordinating body.

3. A general statement concerning the problems of the aging by a member of the Montana Medical Association, with emphasis on the general and mental health aspects of the problem.

4. A young person, preferrably a high school senior, to briefly state what the problems of aging meant to such a young person.

5. Two retirees, one man and one woman, to inform the audience what aging had meant to them.

6. Work shop sessions with the audience divided into seven groups for pur-

poses of informal discussions of the seven specific areas selected by the Montana Committee, namely: general health, mental health, rehabilitation, employment, housing, education, and recreation.

7. A report by some member of each of the county subcommittees making up the region, concerning facilities and services existing for the aged in each county, a report on the gaps which existed in such facilities and services, and, finally, the recommendations, if any, of each subcommittee.

8. A general summary of the Conference by a member of the State Committee or the local chairman.

In each of the six Regional Conferences which were held, the Montana State Committee had a goal which involved an attempt to attain two specific objectives. Our first objective was to create in each local community in Montana, an awareness on their part that problems of aging did exist in their communities, to a degree, and that these problems could best be solved on the local level. Our second objective was to install in each county a desire on their part to make the local subcommittee a permanent one, to continue to deal with the problems of the aging as they would be expected to arise to a greater degree in subsequent years.

There were, of course, other objectives which the Committee had, but which were merely facets of the two principal objectives. We sincerely desired to impress upon those in attendance at each Regional Conference, and on the local subcommittees that we, in Montana, were entering a new phase of our social development. We stressed the point that our rapidly increasing older population, together with the lengthening life expectancy of the individual, were bringing about many problems that were pressing for solution. These were problems of personal adjustment to a changing pattern of living.

We sincerely hope that through our regional conferences we were able to demonstrate the fact that a tremendous potential does exist for the individual community and the nation as a whole through this gift of longer life.

We endeavored, as a Committee, to point out in each Regional Conference that thus far, we could be accused of failure to provide meaningful rules and opportunities for many of the people who are living beyond the commonly accepted period of usefulness and into the new later years.

We pointed out that our task, therefore, and <u>their</u> task as subcommittees, was to establish community services and facilities to help the citizens of their communities make an easier and more graceful adjustment to retirement and old age. The point, however, that should be stressed again and again is that we, as members of the State Committee, looked upon ourselves as a coordinating body—the coordination of the information gathered and facts accumulated by the local subcommittees on the problems of the aging. Further, if we as a coordinating committee could create an awareness on the part of local committees that problems did exist or would, with the passing of time, come to the fore, then we, as a State Committee, had, to a great degree, discharged our obligations and responsibilities.

As specified in the White House Conference on the Aging Act, each State Committee or Commission was to arrange a State Conference on the Aging with such conference to be held prior to the White House Conference in Washington, D.C., in January, 1961. Further, each State Committee or Commission was charged with the responsibility for drafting a final report and of formulating recommendations to be turned over to the delegates to be appointed to attend the White House Conference.

The State Conference on the Problems of the Aging was held in Helena on Saturday, August 6, 1960. Since no set program was set forth for such conferences, the programs presented at many of the state conferences have varied to a great degree.

It was determined by the Montana Committee that the State Conference on the Aging in Montana would concern itself with two specific items: these two specific items, therefore, constituted the greater part of the program held at the State Conference.

The first of these was a summarization of each of the six Regional Conferences,

such summary given by individuals representing each of the six regions. The second major part of the program was a presentation by certain members of the State Committee of the Committee's final report and recommendations in each of the seven areas studied by the Montana Committee.

On the following pages appear the reports and recommendation of the subcommittees concerned with the seven specific areas of research and study by the Montana Committee on the Problems of the Aging. The area reports are listed in the following order:

1. General Health - Dr. James A. Shown
   Dr. Jess T. Schwidde
   Mr. O. A. Bergeson

2. Mental Health - Mr. Louis Wurl, OTC
   Dr. Robert J. Spratt

3. Rehabilitation - Mr. Glenn O. Lockwood
   Mr. Vivian Burr

4. Employment - Mr. Lewis G. Lansing
   Mr. Glenn O. Lockwood

5. Housing - Dr. E. O. Bratsberg

6. Education - Dr. E. A. Atkinson

7. Recreation - Mrs. Don McLaughlin

REPORT OF SUB-COMMITTEE ON GENERAL HEALTH

The general health of the individual aging citizen in Montana can, under no circumstances, be divorced from any of the multiple, environmental factors affecting his life. These factors range from the purely physical--such as food and shelter; to the more intangible social--such as the place he is offered in our present society.

It is, of course, obvious that the general health will be adversely affected by the lack of proper food and housing. During its diligent fact-finding study, the Montana Committee on the Problems of the Aging has developed a rapidly increasing awareness that one factor adversely affects all phases of the older person's life; a factor which is a much more intangible one. It is none the less important. It is more universal and depends little on place of residence, economic status, degree of education, or former occupation. This factor cannot be plotted on graphs, nor can it be summarized in charts. It is the currently negative attitude of our American society toward its aging and aged citizens.

We have placed a premium on youth and a penalty on age. It has become an unreasonable and unrealistic habit, in our society, to pick a certain day from the chronological lifetime of an individual and on that day arbitrarily reduce him to the status of something less than a first-class citizen, regardless of his desire or potential. This time of his life can well be likened to that of an automobile: regardless of "how many miles he has left", he is relegated to the "used people lot." Our young do not look to their elders with respect, nor with equanimity toward their own, inevitable aging. The small inroads that have been made to correct the negative attitude. The older citizen is thus stripped of the basic dignity of man, endowed him by his Creator. This is a blow from which few recover, and cannot fail to have an adverse effect, sooner or later, on his

general health. An unhappy man is a sick man.

We must, then, while considering the general health of our aging citizens, bear constantly in mind this basic disease of aging, our negative attitude, as a society, toward aging.

I. GENERAL CONSIDERATIONS:

Montana has much in common with the rest of the nation, insofar as the problems of its aging population are concerned; however, in some respects it differs sharply.

As is true of our entire society, Montana has an increasing number of people over the age of 65. We rank slightly higher than the national average in this respect. Our people, like all Americans, are living longer. Medicine and its allied fields have increased the life-span in heroic proportions during the past few decades. This has been accomplished by the discovery and development of new medicines to combat many of the acute infectious diseases, to counteract metabolic diseases such as diabetes, and to offset the complications of many chronic ailments. At the same time, development of new methods of anesthesia and surgery, broadened public health procedures, and the growth of the philosophy of preventative medicine have all added long years to the life span of the average American. More infants, children, and young adults live to the later years; and, the elderly have had their lives prolonged.

Thus we see, paradoxically, that while the increase in our aging population represents a tremendous victory for health progress, the same aging population currently represents the area of greatest health need. In 1900 the greatest killers were pneumonia, tuberculosis, diarrhea, heart disease, and kidney disease. Typhoid fever and diphtheria also took large tolls. Today, the list is headed by heart disease, cancer, accidents, cerebral arteriosclerosis (strokes), and kidney disease. Our citizenry is surviving to a remarkable extent the acute diseases with the logical corollary that the percentage chance of living long enough to develop one of the more chronic conditions has been

tremendously increased. This fact, coupled with the still inevitable process of gradual "slowing down" with advancing years, creates a large part of the health problem of our older citizens. Two things, for instance, become immediately obvious:

1. That, just as aging itself is a process that begins with birth and ends with death, so the general health of any individual begins with birth -- or before --. There are no "true diseases of the aged", in the sense that they affect only the elderly. We see many younger people with changes usually associated with old age. On the other hand, many oldsters are seen with remarkable sound physiologies. Abuse of health during the early years is not conducive to absence of disease during the later years.

2. The chronicity of many of the ailments of advancing years, together with the diminished capacity of the elderly to combat the various stresses imposed on the remaining physiological function, automatically requires significantly longer periods of treatment and convalescence. The percentage of disability, in varying degrees, also sharply increases, carrying with it the need for assistance ranging from simple nursing care to complete help at home or in a hospital or other institutional environment.

In the above respects, then, the problem of general health of the older citizens of Montana corresponds well to that in the remainder of the 50 states. But, while this is true, certain fundamentals apply to Montana that are not so generally true. While these differences do not alter the discussion to this point, they certainly do influence, markedly, the methods of attacking the problem. The main points of difference include: large geographic area, relatively sparse population, large rural population, and widely separated urban centers.

II. PRESENT HEALTH NEEDS:

Again, our needs parallel closely the needs in the field of general health

for the aging nationally. The Montana Committee on the Problems of the Aging has gone to the older people for definition of these needs. These people have discussed with us their most urgent needs. These include (not necessarily in order of importance):

1. Convalescent and nursing home facilities. In nearly all surveys there seemed relatively little concern with present or contemplated facilities for management of the acute illness or injury. This definitely did not prove true in the area of convalescent and nursing home care. Almost without exception, each county indicated a definite need for these services.

Not only is there a lack of such facilities, but those available are often below any standard for the providing of decent care. In many instances they are regarded, grimly, as "way-stations on the road to death". Many are found in remodeled homes or other buildings not structurally suited to serving the function for which they are used. Many are inadequately staffed, either in terms of number of personnel or in terms of qualification of the personnel. Too frequently, patients are confined to bed unnecessarily because it is less trouble to do things this way. Too little attention is given each patient. The "extras", of provisions for social, religious, recreational, and rehabilitative opportunites are too often lacking.

At the present time, such facilities are quite often located at some distance from the communities from which the inmates have come. This further "tearing up of roots" at a particularly undesirable time means further loss of identity and interest in living.

To gain admittance to the State maintained home for the aged, the individual must first be committed to the State Mental Hospital at Warm Springs. This procedure was established by the State Legislature and is obviously an undesirable thing.

2. Visiting nurse services. Again, reports from all counties indicated

an urgent need for visiting nurse services. Coupled with this, frequently, is the request for homemaker services, and expanded public health facilities. The latter is particularly true in the rural areas.

With facilities now existent, the preponderant majority of people in the older age groups do or would prefer being cared for in their own homes through visiting nurse and homemaker services, rather than enter nursing homes.

3. Montana at the present time offers relatively little in the way of rehabilitative services for the elderly. This is a definite need.

4. Health education programs, beginning at the lowest school levels, are very urgently needed. It has been pointed out that the health of the older person often is greatly influenced by health habits during his earlier years.

5. Reconsideration of present retirement policies is long overdue. Enforc idleness is not conducive to good general health.

6. Along this same line, the present restrictions of earnings for those who are receiving Social Security benefits is considered unfair by the majority of older citizens.

7. Educational programs for all who serve on the "team" providing care for the older people are urgently needed. This applies to all members of the team, from the physician through the aid. It is also as vital for those providing nursing home care as for such care in general hospitals --- indeed, much more so.

8. A much closer cooperation and understanding between the State Legislature and the various agencies and groups concerned with providing health care is a much needed thing. With lack of such cooperation and understanding the elderly are not considered in their proper light as individuals needing certain care; but, rather, as pawns in political chess games.

9. Special clinic days for the elderly have not been widely sought for. In general, people from rural areas seem little interested. While there is a

much more vigorous request for such a service in the urban centers, a significant proportion of these people, too, indicate they prefer to make their own arrangements.

10. We now come to one of the most urgent needs relating to the general health care of Montana's older citizens. This is, freedom from fear of the prohibitive economic burden imposed by catastrophic illness or injury.

Along with the need to retain his social identity, the older citizen in Montana is most concerned by this fear of becoming completely dependent as a result of chronic disability through illness or injury. This need, unequivocally, must be regarded as one of the foremost problems.

The current trend of our national philosophy toward the principle of "cradle to grave security", based on fact of birth alone, and irrespective of endeavor or merit; has also come to include a large element of "getting all you can for nothing". This is seen with vicious clarity in the number of people who have received extensive and costly treatment in government hospital facilities for "service-connected" illnesses or disabilities which, in actuality, have no connection with service. Many of these people could well pay their own way, rather than impose further burdens on the tax-paying public.

The older citizens of Montana have not, in the majority, subscribed to this philosophy. It is the opinion of the Montana Committee on the Problems of the Aging, based upon extensive investigation, that our senior citizens prefer to retain their individuality and independence as soon as they possibly can, and this includes taking care of their own health needs. True, strong assertions have been made that the "Government" should provide total health care. At least as often, however, have been heard equally emphatic statements to the effect: "let's keep the government out of this". In further explanation of this attitude, these people frequently indicate their feeling that in our society at the present time the idea of getting something for nothing is a myth. Federal

programs cost money, much more than such programs carried on at the community level. In one way or another, these programs must be paid for, and tax increases often negate many of the benefits of such plans. It becomes a case of "robbing Peter to pay Paul"; And, in the final analysis, neither Peter nor Paul will get full value received.

Further, the majority of these people indicate any plan which will further increase their dependence is second-best. More than any other group of people at the present time, our older citizens characterize the principles of individuality and independence of thought and action. They, in general, resent further encroachment, however insidious, by centralized federal control on their individual liberties. They feel, too, that the currently negative attitude toward aging has already created a surplus of undesired, enforced dependence.

Exemplary as this attitude is, however, certain cold facts must be dealt with. In our present sociologic structure, it is not easy and often not possible for the elderly to retain complete independence regardless of the sincerity of desire or soundness of their general health. Among these facts are the following:

1. Increase in cost of hospitalization.
2. Increase in the cost of medicines.
3. Increase in the cost of physician services.

------let it be noted here that these increased costs are often relative. That is, their proportionate increase, when compared with the increased cost of living index, the greater number of lives saved, and decrease in number and duration of disabilities often renders the dollar and cents cost less painful. This fact is not too frequently considered. The actual cost of physician care, per se, has not risen out of proportion to the total increase in cost of living scale. Yet, most people, when asked if doctors charge too much will answer, "yes". When asked, then, if <u>their own</u> doctors charge too much, the answer is

most usually, "no". This too, however, is a relative thing. If the oldster lived under conditions of full earning capacity the charge would not be excessive. However, under his actual conditions of limited, reduced, or fixed income, a very nominal charge may be too much.

4. Increased likelihood of progressive disability, requiring extra care.
5. Sharp decrease in income and monetary reserve.

These facts, and others, point up sharply that we must differentiate between what people "want", and what they actually need. This need must be determined on an individual basis. When it is, realistically, we find that these individuals fall into three main categories:

1. Those older citizens who, through their own resources or through the help of relatives, are financially able to care for their own health needs. This group, diminishing in numbers, presents no acute problem.

2. The eight to ten thousand oldsters in Montana who are partially or wholly dependent upon Welfare funds. These are the group spoken of as indigent. At present their needs are fairly well met.

3. That group or segment, of our older citizens with limited and/or fixed incomes. These are the "marginal" cases. They are not indigent, nor yet do they have sufficient reserve of their own or the outside help to offset the cost of lengthy periods of illness or injury. It is this group which is, at this time, in most urgent need. They are victims of economic and social conditions over which they have no control. These are the people who, on retirement, often find the insurance coverage they have enjoyed, is unavailable to them because they leave group coverage. Individual policies, taken out at that age, are either impossiple to get, carry impossible (for their reduced incomes) premiums, or are subject to restrictions due to certain conditions.

These are the people who frequently do not qualify for full Social Se-

curity coverage. Some of them can get none. We have seen, as we have studied the problem in Montana, many instances of apparent inequities in this regard.

It has been pointed out that Montana has a large rural population. Large numbers of these people, nearing or past the age of active endeavor, find themselves without the fringe benefits provided labor in the industrial areas of the state.

We have thus returned, full circle, to the opening statement of this portion of the report. To a point, our non-indigent older citizens are capable ---and desirous ---of providing for their own health needs. Beyond this individually variable point, complete collapse of resources occurs. A way must be found to lift the burden imposed by catastrophic illness or injury. The consideration must be on an individual basis. An obligation incurred through ill health, might be no problem at all to one individual, a mild to moderate hardship to another, and a completely impossible debt to a third.

The Montana Committee on the Problems of the Aging realizes fully that the time when the complete responsibility for an aging person rested with himself, his family, and his community was irrevocably put behind us by the Great Depression and the resultant change in social concepts. Among these changing concepts has been the delegation of an increasing amount of power and regulation to the federal authority. The Montana Committee is cognizant of the fact that our present social order makes Federal monetary participation necessary, to an extent, in attacking the broad problem of general health for our older citizens. For instance, it does not seem likely that existing Social Security laws, Hill-Burton funds for hospital construction, and so forth, will be done away with. However, the Committee strongly urges that such funds be used sparingly and wisely AND THAT THE ULTIMATE CONTROL AND USE OF SUCH MONIES REST WITH STATE AND COMMUNITY AUTHORITY. Federal assistance, where necessary, is not unwelcome. Federal control is impossible, if the individual welfare

of each of our older citizens is to be our goal. It should be. If it is, the studies of the Committee, in Montana, plainly indicate that one of the greatest needs is for all programs for the health care of the elderly to be activated and conducted at the community level.

III. PRESENT FACILITIES FOR HEALTH CARE OF THE ELDERLY IN MONTANA:

1. Acute Treatment Facilities: With the progressive improvement of hospital, clinic, and office facilities in the larger Montana cities, and, with the construction of modern hospitals in small communities, the gradual expansion of public health facilities (including Public Health Nurses), and a growing awareness of the need for community participation, these acute treatment facilities in Montana seem to be reasonably adequate. The Montana Hospital Association, at the present time, is vigorously involved with efforts to improve the health care of our elderly people --including the indigent.

2. Convalescent and Nursing Home Facilities: The black picture presented to this point, with regard to these facilities, is becoming less dark. The Montana State Nursing Home Association is earnestly attempting to improve these facilities, both in number and in quality. The results of these efforts are evident, for instance, in Missoula. Community joint-action projects, as in Shelby and Conrad, also provide us with functioning proof of the possible results of such action. In some cases the action is begun by a church group; in other by different means. However, such projects clearly demonstrate the benefits of local, community planning for the elderly people of that community. Federal monies have been utilized but the facilities have been adapted to the needs in each community and control remains at the truly effective, community level.

3. The Montana Joint Council to Improve the Health Care of the Aged has been recently organized. It embraces the Montana Dental Association, the Montana Hospital Association, the Montana Nursing Home Association, and the Montana Medical Association. It is within the scope of the Council to provide

effective leadership in the further study and resolution of the needs previously discussed. Prominent among such projects would, and should, be the raising of institutional standards and improvement of the qualifications of those caring for the elderly, in all capacities, through educational programs.

4 The Montana Medical Association, through its Committee on Aging is forging positive action projects in the field of general health care for Montana's older citizens. Again, as is proper, a large part of these efforts are in the sense of education. This education is aimed at the physician as well as the lay public. It is designed to help raise the status of the older patient to that of "first-class citizen"; for, the medical profession has not been immune to the currently negative attitude of our society toward aging and the aged.

5. Facilities for the rehabilitation of older citizens are, at this time, lacking. However, it is anticipated that within the next year, definitive programs will be developed in this regard. Perhaps in no other single phase of general health care is the fact that such care, per se, cannot be divorced from all other aspects of the older person's environment brought home so clearly as in the matter of rehabilitation. The Montana State Rehabilitation Association, composed as it is of a cross-section of occupations and professions, will be in the most advantageous position to stimulate and effect improvement and expansion in these facilities.

6. Present methods of financing health care: Again, we find division into three categories necessary, using the same categories as were discussed in the section on health needs.

A. The group of older citizens, who, through their own resources or with personal, outside help, are able to care financially for their own health needs. This group is becoming smaller.

B. The eight to ten thousand Montanans who are classed as indigents.

These people receive very good care under the Montana Welfare program. People in this class, according to recent figures from the Welfare Department, receive the highest monthly monetary allowance of any of the Northwestern states except Utah, which is a few cents higher. In addition, these people receive a great deal more. Their needs are determined by the Welfare Department, the case workers in each county, and by the action of County Commissioners. Hospitalization, medical care, drugs, and housing benefits are provided. As the cost of living advances, budgetary needs are revised from time to time. The general, overall needs of these people are essentially well provided for. While the Federal Government provides a great deal of these funds, Federal supervision is at a minimum and such matching funds are placed under the control and supervision of the State Board of Public Welfare and the County Commissioners. Budgetary needs for food, housing, and clothing are comparatively simple in administration; and placement in rest homes or arrangements for acute hospital care is generally provided upon the advice of County Physicians. While such programs are not Utopian, they do allow more prompt examination and correction of local inadequacies and abuses. With the stimulus, also, of community supervision there is greater incentive to improve existing facilities. For instance, in one of our larger counties, a particularly active and conscientious County Physician, has been responsible for many improvements in the health care of these people. Homemaker services, for example, are being expanded, and similar plans are in effect. The results have emphasized:

1. Action is more prompt and more efficient at the community level.

2. No program, no matter how well financed or by whom, can be truly effective without the incentive of dedicated personnel.

3. Supervision at the community level allows more exact tailoring and alteration of programs to adapt to changing community needs.

4. Elimination of supernumerary "bureaus" reduces, markedly, the cost of such programs.

5. Where conscientious "teams" of those responsible for all phases of such care are dedicated to the improvement of the social, as well as the medical, lot of these individuals, much money has been saved the taxpayer. For instance, it is well documented that a visiting nurse or a part-time home-maker is able to eliminate many hospital days for the numerous older, indigent patients who are as apt to enter a hospital for social reasons as for actual medical needs.

C. That group of elderly citizens, constantly expanding, who have limited or fixed incomes which do not conform to the cost of living increases. This, as has been repeatedly stated, is the group necessitating the most urgent attention. Let us examine the methods by which they are currently being helped.

1. Retirement and pension plans as provided by industry and/or labor union membership. Understandably, these payments are not sufficient to allow independence, but are of vital concern and of good help to many of the elderly. Unfortunately, it is not infrequent that existing restrictions on added income allowed to recipients of Social Security, render it impossible for full advantage to be taken of pensions, where second pensions or allowances are allowed. Case in point: A Billings man, entitled to compensation for service in the First World War, who is also eligible for retirement benefits from his former occupation, is not able to collect both since to do so would threaten his Social Security status.

2. Prepaid Medical Care - The number of people with voluntary prepaid medical care plans through individual insurance plans or groups, is rapidly increasing. Statistics are not given here because they change from day to day. A specific study of the percentage coverage through prepaid medical plans does not seem either reliable or indicative at this time because of a

currently increasing trend toward utilization of this form of health insurance. A survey in two to five years will prove enlightening.

At this time, for purposes of this report, it is possible, with accuracy, to say only that there is a growing awareness on the part of patient and insurance industry alike of the need of special policies for the elderly. It is the opinion of the Committee that this method of financing health care for the elderly deserves further study and encouragement. For instance, Montana Physicians Service, with the cooperation of its physician members, is offering special, low-cost plans to the elderly in Montana. These plans are not economically prohibitive in premium cost. Montana Blue Cross is enrolling people in similar plans. Various private carriers, with similar recognition of the problem, are offering special plans for the elderly. As with all things, general awareness is slow in coming. Many people in the older age group could afford what would be fairly adequate coverage if they knew of such plans. Education in this regard is necessary.

Recommendations With Regard to General Health Care

1. With the studied realization that changes in the social order, to be feasible and effective, are not to be instituted overnight; but, rather, should be carefully weighed and considered, and that the problems of providing for the general health care of our older citizens imply such changes:

The Montana Committee urges further study and investigation at the community level in order that, as individual states and as a Nation, we search out fairly the problems of our aging. Let not problems be created where none exist, nor let none be overlooked which do exist. Let these problems be wisely and widely studied, in the light of the current awareness of their significance and importance. Let the solution of these problems, conscientiously be sought in the way that is best for our older citizens, for all our citizens, and in the way that will give greatest strength to our Nation.

2. The Montana Committee, cognizant of the need to correct the currently negative attitude in our society toward our aging and aged, before <u>any</u> program can be fully effective, recommends the following:

A. Development of broad health education programs designed to reduce and ultimately remove the current stigma, with resultant impairment of health, attached to the older person.

B. Development of improved programs of preventative health measures for our older citizens.

C. Development of improved standards of care for the elderly in all institutions or other facilities dealing with the aged.

D. Development of increased facilities for the care of the elderly in convalescent and nursing-type establishments.

E. Development of visiting nurse service, homemaker service, and other facilities for the home care of the elderly.

F. Development of definitive rehabilitative services for the elderly.

G. Development of educational programs in medical and other, allied, professional training facilities designed specifically to promote increased interest in and knowledge of the health problems of our older citizens.

H. Re-evaluation of current retirement and employment policies, on the basis that much dependency and inability to care for their own health needs has been arbitrarily produced by such policies, established under different social conditions, and not allowing for <u>present</u> social conditions.

I. The continued development, where possible, of voluntary health insurance programs.

J. Development of community education programs designed to increase the awareness of the general problems of the aging, and to restore the basic dignity of the elderly, with regard to their position in their communities and their society.

COPY

The Montana Committee on the Problems of the Aging for the White House Conference on Aging in 1961

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BOZEMAN

September 30, 1960

Dear Mr. VanOrman

Presented here, in compliance with your request, are corrections and addenda to the Report and Recommendations of the Montana Committee on the Problems of the Aging, section on General Health.

Specifically, the addenda deal with the means of implementing the recommendations. As attempt has been made to briefly but addquately discuss each recommendation from this standpoint. In the event some comments are considered superfluous and you find it necessary to cut them down, the Montana Committee would appreciate an opportunity to review these changes.

If further action is necessary, or if you feel changes are indicated therefore, please advise me.

May I express my personal pleasure at having had the opportunity of meeting you at our Montana State Conference.

Sincerely,

James A. Shown, M. D.

JAS:ar

CORRECTIONS AND ADDENDA: (to the report on General Health---pages 13 through 28 of the Report and Recommendations of the Montana Committee on the Problems of the Aging.)

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CORRECTIONS:

1. Page 13, the sentence beginning: "The small inroads---" in line fourth from the bottom should be deleted.

2. Page 18, line 22, the word soon should read long.

3. Page 22, the final paragraph should include: The Montana Nurses Assoc.

4. Page 25, fourth paragraph. The "case in point," concerning the Billings man inadvertently presents an erroneous conclusion. Social Security payments are affected only by direct earnings, not by pensions. Certain government pensions, however, are restricted by total income.

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ADDENDA:

(Concerning methods of implementing specific recommendations of the Montana Committee)

RECOMMENDATION A:
(Development of broad health education programs)

LEVEL: State and Community

The program implied in this recommendation must necessarily be a long range one. It should be under the jurisdiction of the office of the State Superintendent of Public Instruction. The plan being introduced in Iowa is suggested as a general guide. Initial outlines for such a program in Montana should be blue-printed through joint action by:

1. Office of the Superintendent of Public Instruction
2. Committees from the Montana Education Association
3. Committees from the Montana Medical Association
4. Representatives of other, indicated, groups---i.e., local school boards, Public Health Departments, etc.

The blueprint would then be put into action as a pilot program in one or more community school systems with the necessary evaluation methods. The development of the "blueprint" and of the pilot programs would require more effort than financial outlay. If deemed successful and worthy of inclusion in the state educational curriculum, the State Legislature would be petitioned, in the proper manner, to budget this ~~term.~~ program.

RECOMMENDATION B:
(Development of improved programs of preventative health measures for our older citizens.)

LEVEL: State and Community

In the opinion of the Mmntana Committee, the framework for implementing this recommendation is already existent.
This framework includes:

1. The Montana Joint Council to Improve the Health Care of the Aged.
2. Local components of this organization
3. State Department of Public Health
4. Local departments of Public Health
5. Community social service agencies.

Active cooperation in the provision of services by components of the Council to supplement existent programs budgeted by the Public Health Departments, should mean further federal or state funds should not be necessary. Should minimal, additional funds become necessary they should be requested through County Commissioners. To illustrate the intent of this resolution (and there is a certain amount of overlapping with other recommendations) the following needed program could be rather quickly organized. It could be augmented as experience and need dictates:

1. Special clinic day for the elderly (on basis of need) through the cooperation of component county medical societies, with private and county hospitals providing space and minimal ancillary facilities. Nurse assistance should be on the same basis.
2. Educational programs to include pamphlets on general health care and habits, speakers bureaus for public health forums, etc.
3. Social service departments should function to make certain those who need such assistance would obtain it.
4. Volunteer older citizens and/or local service organizations could furnish staff for clerical and mechanical aspects of the program.

RECOMMENDATION C:
(Development of improved standards of care for the elderly in all institutions or other facilities dealing in such care.)

LEVEL: State and Community

This recommendation applies solely to existing facilities. The newly revised Code for Nursing Homes in Montana has outlined minimal physical requirements for such establishments, including personnel. However, the most modern physical plant becomes little more than a dumping ground for the elderly unless the social spiritual, and recreational requirements are also met.

The Montana Joint Council to Improve the Health Care of the Aged should function to bridge this gap. Again, monetary outlay is not the primary problem. Needed ts integration and education, through existing facilities, as follows:

1. A concerted teaching and educational effort by the Council ---in the nature of a standing program---should be instituted with the following goals:
    a. to interest dedicated personnel in caring for the elderly
    b. to actively and purposefully instruct such people
    c. to establish, through voluntary community participation, recreational, social, and religious programs on a regular and sustained basis.
    d. to improve the quality of individual physical care given each patient.

In larger population centers, where voluntary efforts would be more apt to need direction to remain active and effective, County Commissioners should be petitioned to budget for a director of such activities, to be responsible to the Commissioners and to be guided by a committee of the Montana Joint Council.

RECOMMENDATION D:
(Development of increased facilities for the care of elderly in convalescent and nursing type establishments.)

LEVEL: Community, County, State, and Federal

The Montana Committee feels the projected activities of the Montana Joint Council, as outlined in the preceding recommendation, should also be an integral part of the planning for any new convalescent or nursing home facility. With their specialized knowledge, members of the Joint Council could render great assistance to those individuals or groups contemplating the creation of such facilities, and to the elderly they would serve. This assistance could be either advisory or active as the individual situation would dictate.

Undoubtedly the program authorized by Section 202 of the Housing Act of 1959 will provide stimulus to new construction of such facilities. All such facilities should be designed specifically for the people and the communities they will serve.

RECOMMENDATION E:
(Development of visiting nurse services, homemaker services, and similar programs for improved home care for the elderly.)

LEVEL: State and Local Public Health Departments.
City-County-State Welfare Departments.

Development and/or expansion of visiting nurse service will probably begin with community public health departments. However, considering the long range outlook, many of the larger counties, through their health and welfare departments may eventually budget for visiting nurse, homemaker, and similar services for the elderly. Well-documented conservation of funds expended on health services through the use of such facilities should permit their inclusion under county authority.

Many elderly citizens in each community could be usefully and gainfully employed as visiting homemakers, cooks for meals on wheels, etc. This recommendation should evolve as a community enterprise to supplement such facilities provided by departments of public health.

RECOMMENDATION F:
(Development of definitive rehabilitative services for the elderly)

LEVEL: State and Local

Existing and potential facilities, coordinated and fully utilized, could quite satisfactorily handle most of the problems in Montana. In Montana, rehabilitative services, in general, are in their relative infancy. Further information is needed. Logically the Montana Association for Rehabilitation, with the assistance of the Montana Joint Council, is in the best position to determine: present and future needs, existing and potential facilities, and the most propitious methods of developing an adequate rehabilitation program. During the 1961 year, this is the intended dedication for the Montana Association for Rehabilitation.

RECOMMENDATION G:
(Development of educational programs in medical and other, allied, professional training facilities, designed specifically to promote increased interest in and knowledge of the health problems of our older citizens.)

LEVEL: Institutional, AMA, and allied professional agencies

The Montana Committee feels the American Medical Association, through its various committees dealing with all levels of physician training, should actively stimulate changes in curriculi designed to meet the above recommendation. Other professional associations, touching in any way on the health care of the aged and aging, should provide similar leadership.

RECOMMENDATION H:
(Re-evaluation of current retirement and employment policies.)

LEVEL: State and Local. Federal?

Employment and retirement policies ultimately become a matter for decision in individual industries. The Montana Committee questions the necessity and the desirability of federal laws dealing with employment and retirement on the basis of age. Should legislation be required to correct current outmoded and unrealistic concepts, action at the state level would more accurately serve the needs of each, individual state.

There is a a growing awareness, nationally, that present concepts are outmoded and unrealistic. Industry surveys, educational programs, and similar measures should be continued and encouraged at all levels. Projected job openings and analysis of the labor force to be available to fill them indicate practical needs of industry will favor adoption of fewer restrictions on basis of age.

RECOMMENDATION I:
(Continued development of voluntary health insurance programs)

LEVEL: Community, Health Insurance Companies, to include Blue Shield-Blue Cross

Protagonists and antagonists of voluntary health insurance programs present radically different opinions of the effectiveness of thismeans of meeting a part of the health needs of the elderly.

The Montana Committee submits that insufficient time has passed for definitive evaluation. In studies in Montana would indicate that such programs should be encouraged. Many individuals are satisfactorily covered in this way, and prefer it. Many more DO NOT KNOW ABOUT SUCH COVERAGE, but could now get it at reasonable rates and with satisfactory coverage.

All agencies purveying such coverage should step up their educational program to more adequately inform the public, on a community to community basis. Individual physicians should become fully informed in such matters, that they might assist their individual patients in obtaining proper coverage.

RECOMMENDATION J:
(Development of community education programs designed to increase the awareness of the general problems of the aging.)

LEVEL: Community

These recommendations, made by the Montana Committee, are made with the further, general recommendation, that wherever possible, all such activities be conducted at the local, community level. Federal funds, where necessary, should be administered at the local level. The problems, differing from individual to individual, and from community to community, are best solved on this basis. It is our firm conviction, as individuals and as a Committee, that, while Federal assistance may be necessary, Federal control must be avoided.

Dr. James A. Shown, Chairman

REHABILITATION PROBLEMS OF THE AGING

MEDICAL REHABILITATION

During the last fifty years the rate of increase of the number of persons sixty-five years and older has been twice that of the population as a whole. In the nation today persons over sixty-five years represent 8.6% of the population, where fifty years ago this group represented 4.1% of the population. In Montana 9.4% of the population is composed of persons sixty-five years and older.

Because of this rapid lengthening of the life span, all of the needs of older people have been brought into clear focus. In particular, the medical care needs of older people have become an increasing responsibility of those outside the immediate family group.

Terminal and disabling physical conditions have been prevented and postponed to contribute to the increasing life span. But, as the life span continues to increase, more attention must be given not only to the preventable and postponable aspects of illness and disease, but also to the medical rehabilitation of aged people whose physical condition will submit to rehabilitation.

As more and more aged people enter hospitals and other facilities which offer different aspects of medical care, it becomes clearer that it is necessary to help these people become physically rehabilitated to the extent that they can leave the remedial care facilities to again live independently in their communities.

As the need for preventive treatment and rehabilitative medical care for the aged increases, it is recognized that there is need for more facilities and more personnel to meet these needs. New fields of specialization are developing in medicine and in therapy in relation to meeting these needs.

Montana must be prepared to do its part in contributing to the advances in these new fields of medicine and therapy. Resources can be pointed to even though they may not be as adequate or as fast-growing as some would hope.

In recent years the medical association of the state has developed and active committe on geriatrics, and has helped to increase the interest of many doctors in understanding and working with the medical problems of the aged. Hospitals have established geriatrics wards where space and other facilities have been warranted. Other hospitals which cannot set aside such wards have improved their general facilities to the extent that they are much better able to handle both their acute illness patient and the convalescent patient among the age group.

More and more nursing homes and personal care homes have opened their doors in recent years especially to serve the aged. In very recent years insurance companies have made available to the aged, policies which will take care of many of the medical care needs of older people. All of these resources lead to more medical rehabilitation and, thus, make a continued contribution to the physical comfort in people's later years.

Although the reservoir of resources which contribute to medical rehabilitation has become larger, it is not building as fast as the needs of the aged demand. Not enough medical care is available to older people. Not enough hospitals are equipped to give the special services needed in geriatrics. Many of the nursing and personal care homes which have opened in recent years are not suitable as facilities nor do they have the qualified personnel to meet the needs of the aged.

In general, older people are unable to purchase medical insurance let alone purchase medical care in the open market. Some of these needs will be met in the foreseeable future, but many of the needs will not soon be met at all without drastic changes.

The medical care needs of persons who are not able to purchase them for themselves will remain outside of their reach until state statutes are brought up-to-date to meet the conditions of today rather than the conditions that existed a half century ago when the statutes were put into the law books.

Just recently, legislation was enacted to provide for standards in relation

to nursing care and other sheltered facilities. It will take several years, of course, to develop an adequate number of nursing homes under these new standards.

INDEPENDENT LIVING

We can say with at least some degree of accuracy that today we have some 64,000 persons living in Montana who are sixty-five years of age or older. Approximately 10% of this number have applied at employment offices for work, thus indicating that, for one reason or another, they must supplement what income they have with something additional. Now, what of the other 90% of this group; how are they managing, and what are their problems?

Many of them are faced with serious housing problems, or with grave physical and mental health factors. But there are some who can be enabled to live a satisfactory and independent life through the provision often time of a relatively minor service. This would be the group of older people who are suffering from some type of physical or mental disability which can be either eliminated or greatly reduced through services of rehabilitation centers and other facilities. Thus, institutional care for many may be terminated, or even the need for an attendant's care at home. Dignity and self-respect will be restored to these people, as they no longer have to depend upon others for even the simple necessities of life. Some may even profit from vocational rehabilitation services to the extent that they might become completely independent form a health viewpoint and become employable once again.

These are some of the results that might be achieved through H. R. 3465 by Congressman Carl Elliott. Purpose of the bill is to provide rehabilitation potentials and services to handicapped individuals who, as a result thereof, can achieve such ability of independent living as to dispense with the need for expensive institutional care; to assist in the establishment of public and private non-profit workshop and rehabilitation facilities. For the most part these would be people who are not now eligible for vocational rehabilitation services due to the sever-

ity of their disability, advanced age, or other factors. Often their dependency upon others may be greatly reduced by the provision of a brace of other adaptive device, therapy in a rehabilitation center or other facility, or perhaps some work training in a sheltered workshop.

For example let us consider the case of an elderly retired man who is a bilateral leg amputee. He and his wife own their home, and have sufficient retirement income for the two of them to live comfortably. But, although he had two good artificial limbs, he is unable to walk or move about, other than in a wheelchair. He is almost completely dependent upon his wife for everything he does, and neither one of them are happy with the situation. Then his doctor referred him to an out-patient rehabilitation center. Here he received a complete medical, social, and psychological evaluation, and a therapy program was set up for him. For three months he spent an hour or two a day conditioning the stumps of his legs, once again learning to balance himself, to put on and take off his appliances, to get in and out of bed and a chair, and finally to ambulate, to get up under his own power and go where he wanted to with no help from anybody else. In that time he really achieved what we would call "independent living."

To carry out treatment or therapy programs such as the one just mentioned, we must have the proper facilities. We need rehabilitation centers and facilities, we need prosthetic appliance teams consisting of a doctor, a prosthetist, and a physical therapist to aid the handicapped in being fitted satisfactorily with an appliance. And we need sheltered workshops wherein work capacities of the severely handicapped can be evaluated and developed, and can also be used in the productive work in cases where the handicapped individual is not absorbed in the competitive labor market.

With the ever increasing group or older workers in our society, and the much larger group of elderly people who are not possible workers, but who are handicapped in some way or other and very difinitely do have other problems, the im-

plications nationally for independent living services are tremendous. We could anticipate that such a program would greatly affect the work load of public and private welfare agencies, or vocational rehabilitation agencies, and of health organizations.

SOCIAL SERVICES

Rapid changes have taken place in more recent years which have affected the aged person in relationship to his own family, to his immediate community, and to the entire universe in which he operates. The younger members of families no longer find it possible to provide the full care to the elder members of the families that was the custom a generation or two ago.

Because the older members live so much longer, they expect to remain independent to a greater age than was possible in previous years. Aged people now must plan to live independently of their families even though this may be somewhat distasteful to them.

It cannot be expected that the aged will be able to meet their many needs without outside help. More and more often this help must now come in the form of counseling services and in social services. Not only is there a growing community awareness of these needs, but there has been provision of these services as a natural outgrowth of several titles of the Social Security Act. The Social Secuity amendments of 1950, 1952, 1954, 1956, and 1958 have made specific mention of the need for social services to the aged.

In recent amendments to the State Public Welfare Act, the provision of social services has been made a mandate of the Public Welfare Department. The Public Welfare Department is not the only medium through which social services and counseling can be made available to the aged population. Voluntary agencies have begun to accept a responsibility in this area to the extent that their limitations allow. Churches and those dedicated to the ministerial life are providing counseling and services in a meaningful manner. Community organizations are spring-

ing up to help meet many of these needs.

In many instances, however, aged people are fully able to maintain complete independence through their later years. The greatest service that can be provided for this group is to allow them to function independently. There is need for greater understanding on the part of all people of the problems which must be met by the aging population. There is need for acceptance on the part of people that social services for this group are as natural on the part of government as providing such services as fire protection. There is need for voluntary agencies to expand their services to the aged to the same degree that voluntary agencies were developed in the past to provide services for children.

It must be recognized that counseling services, casework services and other related social services must be purchased for the aged group by the earning group.

VOCATIONAL

In 1956 some 3,000 persons became sixty-five each day, and 1,000 persons sixty-five or over died per day. This means a net increase of 1,000 daily. Yet 60% of those over sixty-five received an income of less than $1,000.00 for the year. They are at once confronted with the problems of securing adequate housing they can afford, of proper medical and hospital care, of well-equipped rehabilitation centers and other such facilities.

And this same group is faced squarely with problems of a vocational nature. With inadequate retirement income to meet even their minimum needs, more and more are forced back upon the labor market. Some may have developed highly technical skills which would enable them to resume satisfactory employment again without too much difficulty. For others there would be practically no opportunities for a job, due to many factors - age, health, attitude, lack of skills or training, etc. These older citizens may well have to depend upon family, private or public resources to supplement their own meager income.

Yet there is another segment of this same group who not only have a vocational and employment problem; they still have something to offer and simply need a little help and understanding from the community. Perhaps some can become employable with a sound vocational evaluation, and some brief training. For others, the provision of a badly needed brace, artificial limb, hearing aid, or wheelchair might be all that is needed to clear the way.

Of inestimable importance in this return to employment by some of our older workers would be the removal of arbitrarily established retirement ages. The selection of sixty-five as the retirement age was a product of the depression era of the thirties when the emphasis was to make room for younger workers. Now, with near full employment, why could not this retirement age be abolished? A few states - Massachusetts, Rhode Island, Connecticut, Pennsylvania, and New York - have already done this.

Probably above all we need a solid local organization such as is represented here today. Our efforts should be combined in establishing a total community rehabilitation program, for we have the resources at hand. What we do in this area will be limited only by the work and imagination our leaders wish to exert.

ECONOMIC NEEDS

The problem most common to older people is meeting economic needs. Economic need would embrace the costs of food, clothing, shelter, utilities, personal needs, and medical care.

As people live longer, more and more of them out-live their own resources developed to meet their needs when aged. Families who used to be counted upon to take over when the resources of the elder members of the family were gone, are less able and become increasingly less able to take care of these economic needs.

For many years it has been recognized that meeting the economic needs of the aged is a burden that must be accepted by society. Early in this century states began to make provisions for their aged population. The depression of the 1930's

pointed up clearly that the problem was one too large for the states and localities to handle. Recognition that the problem must be met by the entire society resulted in the passage of the Social Security Act in 1935.

Title I of the Act made provision for assistance to aged people sixty-five and over through a combined use of Federal, State, and local funds.

Title II of the Social Security Act provided the basic plan under which people and their employers would jointly contribute to an insurance plan which would be payable after retirement at age sixty-five or older.

In the twenty-five years of the Social Security Act, the insurance program has progressed to the point where more than 90% of the working population is covered. Payments in many instances now when retirement age is reached, are sufficient to meet the total needs of covered individuals.

Consequently, there is less and less need for the Old Age Assistance program. In Montana a high of 12,500 people received Old Age Assistance. Today the recipient load is down to approximately 6,900. This caseload has been decreasing at the rate of approximately 500 per year for the past several years.

It can be said now that the group needing Old Age Assistance is the residual group of people who had no OASDI coverage or whose coverage was not adequate to meet full need. It can be expected that in time OASDI will meet the needs of 90% of the retired people so that the tax supported program of Old Age Assistance will be a minor one.

One of the major improvements in the insurance program was the addition of payments to disabled people age fifty or over. It is expected that this program will be broadened to cover disabled people under the insurance program regardless of age.

The great debate of today is whether medical insurance should become a part of the total Social Security program. For the first time since the passage of the Social Security Act, Congress is giving full consideration to the passage of medical care insurance laws for the aged.

STATE OF MONTANA
DEPARTMENT OF PUBLIC WELFARE

W. J. FOUSE, ADMINISTRATOR AND SECRETARY TO THE BOARD

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HELENA, MONTANA

September 28, 1960

Mr. Francis A. Howard
Western Life Building
Helena, Montana

Dear Francis:

This is the information requested in your letter of August 16, 1960 to pass on information to William T. Van Orman.

Recommendation No. 1 "The matter of medical care for the aged needs full exploration at every level of government" indicates in itself that work should be done at all three levels of government on this recommendation.

Our second recommendation "Older people need to be informed and reassured that somewhere medical care and rehabilitation are available if and when needed" should be implemented through greater development of local communications and public relations.

The third recommendation "Locally there should be plans for preventive and rehabilitative services designed to keep older people out of costly facilities" calls for local actions for the most part. However, obviously it will be difficult for most localities to develop such plans, so local action may well be in the direction of developing area facilities with, of course, help from State and Federal sources.

Recommendation No. 4 "Convalescent hospitals and nursing homes should be equipped with rehabilitation facilities to help older people return to their own homes." Since these facilities exist in few localities this again would be a development arising out of a combination of many groups working together and calling upon resources at every level of government.

The fifth recommendation "Social services should be available to older people who anticipate or who have medical problems as a help in making total plans to meet these problems." Primarily these services should be developed within local departments of public welfare. Since this has the support of national legislation, there is already considerable impetus

toward the development of these services.

The sixth recommendation "There should be refresher training and rehabilitation courses for older workers out of the labor market but in need of a job." This responsibility should be divided among many agencies, some of them Federal, some State, and some local.

Recommendation No. 7 "Adult education classes could be established to give courses that would help older people re-achieve independent living" would call for action at both State and local level; mainly involved would be the educational systems.

The eighth recommendation "Further study of the need for speeding the legislative processes to achieve a national program of independent living" is one which first needs initiatory activity at the national congressional level.

The ninth recommendation "There should be sheltered workshops where elderly people can participate in useful work activities for therapeutic values, rather than for income purposes" is something that should be a responsibility of each locality.

Very truly yours,

STATE DEPARTMENT OF PUBLIC WELFARE

V. A. Burr, Director
Division of Public Assistance

cc

RECOMMENDATIONS

1. The matter of medical care for the aged needs full exploration at every level of government.

2. Older people need to be informed and reassured that somewhere medical care and rehabilitation are available if and when needed.

3. Locally there should be plans for preventive and rehabilitative services designed to keep older people out of costly medical facilities.

4. Convalescent hospitals and nursing homes should be equipped with rehabilitation facilities to help older people return to their own homes.

5. Social services should be available to older people who anticipate or who have medical problems as a help in making totals plans to meet these problems.

6. There should be refresher training and rehabilitation courses for older workers out of the labor market but in need of a job.

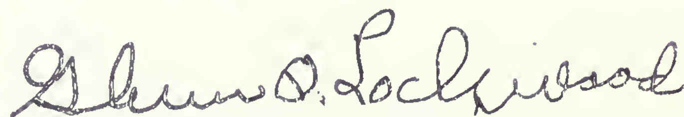
7. Adult education classes could be established to give courses that would help older people re-achieve independent living.

8. Further study of the need for speeding the legislative processes to achieve a national program of independent living.

9. There should be sheltered workshops where elderly people can participate in useful work activities for therapeutic values, rather than for income purposes.

Report submitted by

V. A. Burr, Director
Division of Public Assistance
Montana Department of Public Welfare



Glenn A. Lockwood, Director
Bureau of Vocational Rehabilitation

I. THE PROBLEMS

Older workers who are seeking employment begin to have difficulties when they reach age 45. For women, the problems begin as early as age 35. The problems arise because many employers arbitrarily set a top age limit on the people they hire.

In a survey conducted by the U. S. Department of Labor, the main reasons given for not hiring older workers were as follows in order of frequency:

1. Cannot maintain normal production standards - too slow.
2. Cannot meet company physical requirements - lack strength, endurance, health, not able to pass physical examination.
3. Too set in their ways - resist change or supervision, will not accept new ideas.
4. Pension costs would increase due to age.
5. Would be absent from work more than younger workers.
6. Would have more accidents and raise liability rates.

It was said that the upper age limits set by employers for hiring workers were arbitrarily determined. This statement is true because the facts do not bear out this determination. It is a fact that the reasons usually given for not hiring older worke s could apply to certain individual older workers, who have some disability or lack of education and certain types of experience. But, the same can be said of individuals in the age group from 20 to 45. To arbitrarily apply the negative reasons to the whole group of workers in middle age or older is a false assumption.

To find out whether this assumption was false or true, the National Association of Manufacturers, the National Office Management Association, McGraw-Hill Publishing Company (Business Week), the University of Illinois and the U. S. Department of Labor sent inquiries to hundreds of employers in all types of industry. The employers replied overwhelmingly that the over-40 employee was

equal or superior to other workers in attendance, safety records, work attitude, loyalty to company, dependability, response to supervisor and getting along with others. The replies with regard to lateness and turnover were likewise in favor of the older worker. The National Association of Manufacturers survey was pointed toward productivity of the older worker when compared with younger workers. Replies were received from 3,800 companies and the composite result revealed that 92.7% of the over 40 workers were equal to or better than younger workers in production. These findings answer most of the reasons given by employers for not hiring older workers, but there are still two reasons for which no contradictions have been given, namely, lack of physical strength to do the job and the cost of pensions and retirement plans.

Practically all retirement pensions today are based on the salary of the employee and the length of time contributions are made by either the employer, the employee or both. An older worker will be with the employer a shorter length of time and thus cost less. Very few of the pension plans have cost based on age of the employee. In those few the additional cost, if any, is more than offset by the gains made by hiring an experienced, steady, reliable and productive employee.

As for older workers having the physical strength to do most kinds of work, it doesn't take a circus strongman to drive a truck, to be a salesman, to work in a store, to be a bookkeeper, to be a machinist or even a warehouseman. Labor saving machinery such as hydraulic lifters, overhead cranes and tracks and motorized trucks have eliminated most of the need for a strong back. There isn't ten per cent of the jobs in the country that require any marked degree of physical strength in this modern day.

Why then, with the facts of life being as they are, do many employers persist in being reluctant to hire the older worker? It is a carry-over from the past.

A cut-off age of 45 or even 35 seemed reasonable in 1900 when the average life expectancy of man was only 46 years. Their policies certainly do not mesh with the situation in 1960 when the average life expectancy of man is 67 and 73 years for a woman. Today with a labor force of about 73 million in the country, 27,900,000 or one-third is over 45 years old; it is hardly realistic to expect all of the jobs in the country to be filled by only two-thirds of the workers.

By 1970, or during the next decade, some startling developments will take place in the composition of the four major age groups of workers. It is expected that the working population will increase 20% and reach 87 million. There will be 14 million more people working or seeking work. But the increases will not be the same in all age groups. By far, the greatest increases will be in the workers under 25 and those over 45. The under 25 group will increase 6.4 million or nearly half of the total increase. The workers over 45 will increase nearly as much as 5.5 million. These two groups will account for 11.9 million of the expected 14 million total increase. Workers from 25 to 34 will increase only 1.8 million and there will be an actual decrease in the number of workers from 35 to 44 by 200,000. The big jump in younger workers under 25 is due to the very high birth rates in the late 40's. The large increase in workers over 45 is the result of greater longevity, which is enlarging the older segment of the population at a rapid pace. The small increase in the 25 to 44 group is due to the low birth rates in the depression of the 30's and the casualties of World War II. (See Table A)

This changing labor force picture should have a marked influence on the hiring practices of all employers. The smart employer is going to begin to use the available older workers and he is probably not going to be so prone to retire workers who can still produce valuable services to his business. If employers do not change their hiring practices and still insist on hiring only the misnamed "cream of the crop" group between 25 and 44, they will find that there are not enough of such

workers to fill their jobs.

THE MONTANA PROBLEM

Now let us see how this problem of restrictive hiring, which makes it difficult for older workers to obtain employment, operates in Montana.

On June 15, 1960, the Montana State Employment Service requested its 22 local employment offices to make a survey of the job openings which were listed with them on that day to determine how many of the job openings had upper age restriction which would prevent older workers from being hired. On that day, the offices had 754 job openings listed. Of that number, 285 or 43% of the openings had some sort of restrictive age limits. In 203 of the openings, employers would not hire anyone over 45, and 120 of the openings had to be filled by job applicants under 35. The largest number of restrictions were not in laboring jobs or construction work, where these might be expected, but in clerical work, sales jobs and service occupations in which mature workers with experience and stability would naturally contribute more. Montana employers, too, have outmoded unrealistic hiring policies. (See Table B)

The Bureau of the Census made an estimate of the number of workers over 45 in Montana in 1955. The figures for the 1960 census are not yet available, but applying the previous percentages to the population count of this spring, Montana has 88,660 persons in the labor force who are over 45 and 16,900 of these who are either working or seeking work are over 65. If Montana's population increases at the same rate that it did in the past ten years, by 1970, we will have just over 100,000 of our citizens who are in the labor market over 45 years of age. (See Table C)

From the reports of the Montana Regional Conferences, it would appear that employment of older workers is not much of a problem in the rural agricultural counties. It was reported from a number of such counties that the older age group usually were only semi-retired from farming and ranching activities and put in as much time working on their former farms as they desire. Even in the smaller towns of the

state the employment problems of older people was not reported to be extensive. It can be concluded that in the small communities everyone knows everyone and employers know the capabilities of such older persons who want to work and hire on the basis of ability and not age.

In the large cities, the State Employment Service reports the situation regarding restrictive hiring is a serious deterrent to finding employment for older workers. Men of 45 or over are not wanted by over 40% of the employers and women over 35 are in the same predicament. From surveys conducted, the most serious conditions are existent in the largest cities of Billings, Butte and Great Falls. In all three of these cities, nearly one-third of the job seekers in the Employment Offices are older workers and the offices are able to place only about 20% of them in jobs because of age restrictions. Unemployment rates for older workers due to seasonal fluctuations of the labor demand are no higher than for younger workers but the older workers stay unemployed longer because they have fewer chances for re-employment due to the age restrictions. (See Table C)

II. RESOURCES

The principal governmental resource for assistance to older workers in finding employment is the Montana State Employment Service and its 22 local offices throughout the State. In 1956, the Bureau of Employment Security in the U. S. Department of Labor became fully aware of the problems of the older worker and set up an Older Worker Division to give special attention to a solution of restrictive hiring practices. The State Employment Services are 100% supported by federal funds supplied by the Bureau and all states were requested to train their local office personnel to give older workers preferential treatment in employment counseling and assistance in job finding. A small amount of money was allocated to provide for an Older Worker Specialist in each state and for training Specialists in all local employment offices. Numerous pamphlets and publicity stories have been released since 1956 to make

employers aware of the fact that they are missing out on about one-third of the available workers if they restrict their hiring to younger job applicants. When job openings, with age restrictions, are listed by an employer, if the local employment office has an older worker who can fully qualify for the openings, the employer is encouraged to interview the older worker first before he talks to younger applicants. By this technique many more older workers are placed in employment than by adhering strictly to the restricted age limit in referring applicants for interview.

In some parts of the country, various service clubs provide various types of assistance to encourage employers to hire older workers. There has been little of this done in Montana.

Trained employment counselors in the Employment Service offices are available to counsel older workers on their employment problems and help them understand their abilities in relation to job opportunities.

The Montana Bureau of Vocational Rehabilitation has various services which can increase the employability of older workers. This is explained in Report on Rehabilitation.

III. CURRENT AND FUTURE NEEDS

The greatest need is for an extensive educational program to bring the facts and figures to the attention of employers. Surveys from many sources have shown that older workers are equal to or superior to younger workers in most jobs and positions. Older workers bring experience, stability and judgment to jobs, and their production i just as good as younger workers to at least age 55. Every Regional Conference highlighted the need for older people to keep up their interest in life and what goes on about them and to keep active. Employment is the solution for many of them. A compulsory retirement age cuts off many capable employees who want to continue working. It is hard to understand the attitude of some employers whose policies are to have a good productive worker one day and the next day, because of a birthday, the

workers become senile or superannuated. Employers need to know that the supply of workers in the "cream of the crop" ages from 25 to 44 is just not going to be available within the next few years. All of these facts need to be forcibly impressed on employers by word of mouth, news outlets, local committees on aging, service clubs and every means available. It is not charity to hire older workers - it is just plain good business.

Both the State Employment Service and the Bureau of Vocational Rehabilitation could give much better individualized service to older workers if these agencies had additional personnel and time to devote in that direction. Being public supported agencies, it is necessary to demonstrate the value of such an activity before money is forthcoming to enlarge operations. This creates a paradox because without additional personnel the job cannot be adequately done. The situation is probably best handled by the agencies themselves doing the best they can and relying on accumulated results to prove their needs.

IV. RECOMMENDATIONS

1. State, area and local committees on aging assist the public agencies in the education of employers in the logic and value of hiring new employees on the basis of ability without regard to age.
2. Service clubs and other civic organizations to encourage forums on employment for older workers.
3. Continuing distribution of available and new pamphlets and material on the value of older workers to employers.
4. The State Employment Service and the Bureau of Vocational Rehabilitation arrange their operation to give increased emphasis and effort to the employment problems of the older worker.
5. All interested parties dispell the following myths and hammer home the following facts:

The Montana Committee on the Problems of the Aging for the White House Conference on Aging in 1961

The Honorable J. Hugo Aronson
Governor of Montana

Robert B. Richardson
Chairman
Helena, Montana

Ralph C. Knoblock
Vice-Chairman and Secretary
Western Life Building
Helena, Montana

Mrs. Gladys Knowles
Member National Advisory Committee
Billings, Montana

Dr. James H. Shown
Great Falls
Mr. Lewis G. Lansing
Helena
Mr. Leif Fredericks
Helena
Mr. Vivian Burr
Helena
Dr. Robert J. Spratt
Warm Springs
Mr. O. A. Bergeson
Dillon
Dr. E. O. Bratsberg
Kalispell
Mrs. Don McLaughlin
Butte
Mr. L. A. Christenson
Cut Bank
Rev. Msgr. D. B. Harrington
Helena
Dr. Jess T. Schwidde
Billings
D. A. Atkinson
Missoula
Dr. David T. Berg
Helena
Mr. Louis W. Wurl
Warm Springs
Mr. Richard Lubben
Bozeman

August 26, 1960

Mr. William T. Van Orman, Regional Representative
Program on Aging
Room 551
621 17th Street
Denver 2, Colorado

Dear Mr. Van Orman,

Chairman Knoblock of the Montana Committee on Problems of the Aging has asked me to advise you of what levels the recommendations on Employment Problems of the Aging should be carried out.

As you know, employment problems of the aging stem principally from employer attitudes. They arbitrarily set an age limit on new employees whom they hire, which eliminates the possibility of older workers finding gainful employment. They also arbitrarily retire workers at a fixed age regardless of ability to do the jobs.

Attitudes, which are general throughout the country, require educational efforts at all levels - federal, state and local. Considerable progress has been made by the Bureau of Employment Security and its affiliated state employment services since 1956 when the Older Worker Program was started. But the surface has barely been scratched even though much effort has been expended at federal, state and local levels. Much more could be done if sufficient personnel time was available.

The Employment Service is 100% federally supported by Congressional appropriations. For the past three years, the Montana State Employment Service has received funds to pay for only one-half of one person's time to be devoted specifically to the Older Worker Program. It is ridiculous to expect great progress through our agency under these circumstances. Regardless of the allocation, our personnel have expended at least ten times the amount actually given us by "stealing" time from other programs. Even the Bureau has eliminated a staff position which was set up to administer the Older Worker Program. So there is much that can be done at the federal level.

If it is possible to maintain active state and local committees on problems of the aging to co-operate with and assist public agencies in changing employer attitudes, a great deal could be accomplished. The influence of friends, neighbors and customers in matters which can be localized and individualized is of much more value and significance than generalized statements and propaganda issued by others.

In conclusion, interested parties at all levels can be of assistance in encouraging employers to hire workers on the basis of ability without regard to age.

Sincerely yours,

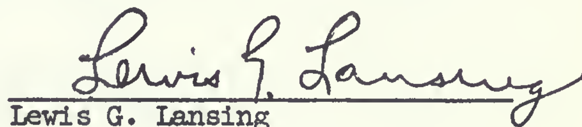
Lewis G. Lansing

cc: Francis Howard, Vice Chairman
% Western Life
Helena, Montana

MYTHS Reasons Employers Give for Not Hiring Older Workers.	FACTS As Determined by Labor Department and other Studies.
1. They are too slow and cannot meet production requirements.	1. Studies of age and performance in 8 plants show no significant decline until after age 55 and then only a small drop and wide variation in individual output in all age groups.
2. They cannot meet the physical demand of the jobs.	2. Extensive job analyses shows only 14% of jobs require great strength and heavy lifting. Among older job seekers, 5 of 6 had no vocational handicap for jobs for which they qualified.
3. They lack the skills and flexibility to meet changing job conditions.	3. Thorough evaluations of older job seekers' characteristics shows a high proportion with skills and considerable flexibility in accepting change in industry, occupation and earnings.
4. Hiring them greatly increases Pension and Insurance costs.	4. A distinguished group of experts report that under pension and insurance plans most prevalent today there is no significant increase in costs for new hires of older workers.

HIRE ON THE BASIS OF ABILITY, WITHOUT REGARD TO AGE

Sub-Committee on Employment



Lewis G. Lansing

Glenn O. Lockwood

TABLE C
MONTANA

LABOR FORCE 1960		ESTIMATED TOTAL - 260,000
Age	Per cent of Total	Number Over 45
45 - 64	27.6%	71,760
Over 65	6.5%	16,900
Over 45	34.1%	88,660

LABOR FORCE 1970	ESTIMATED TOTAL - 294,000
Age	Number Over 45
45 - 64	81,144
Over 65	19,110
	100,254

* *

Montana State Employment Service Operation for Year Ending June 30, 1960:

Total Jobs Filled - All Ages	75,092
Work Applications - Over Age 45	10,354
Female	2,543
Jobs Filled by Over 45 Workers	6,960

TABLE A

OLDER AND YOUNGER WORKERS WILL ACCOUNT FOR MAJOR SHARE

OF CHANGES IN WORKING POPULATION

IN THE UNITED STATES

THERE WILL BE:	1960 (Millions)	1970 (Millions)	CHANGE 1960 to 1970 Numbers (Millions)	Per cent
Many More Young Workers Under 25	13.8	20.2	6.4	46
A Relatively Small Increase Among Workers 25-34	15.3	17.1	1.8	12
Actually Fewer Workers Age 35-44	16.6	16.4	- .2	- 1
Larger Numbers of Older Workers	27.9	33.4	5.5	20
	73.6	87.1		

Upper Age Restrictions in Job Openings
By Occupational Group and Age

June 15, 1960

JOB ORDERS	
Total Orders	717
Male	397
Female	320

	TOTAL	Prof. and Mgr.	Clerical	Sales	Service	Agric.	Skilled	Semi-Skilled	Un-Skilled
TOTAL JOB OPENINGS	No.	No.	No.	No.	No.	No.	No.	No.	No.
	754	30	139	89	202	88	58	61	87
TOTAL Openings Without Age Restrictions	469	22	68	58	134	78	40	31	38
TOTAL Openings With Age Restrictions	285 43%	8 27%	71 51%	31 35%	68 34%	10 11%	18 31%	30 50%	49 56%
OPENINGS WITH AGE RESTRICTIONS: Under 35*	120 43%	5 61%	39 55%	21 68%	20 29%	4 40%	6 33%	16 53%	9 54%
35-39 *	27	2	16	1	3	0	2	3	0
40-44 *	56	1	8	2	12	4	7	6	16
45-54 *	66	0	8	2	22	2	3	5	24
55-64 *	15	0	0	5	10	0	0	0	0
65 and over*	1	0	0	0	1	0	0	0	0

REPORT ON RECREATION

The word "recreation" as termed in Webster's Dictionary means: refreshment after toil, amusement, the act of recreating anew or a new creation. In regarding this definition in relation to our subject of Senior Citizens, it seems to me that refreshment after toil is certainly applicable ---- after a lifetime of toil. In further relationship, the term could also be interrelated to mean creating anew ---- a new life for the Senior Citizen.

This process of creating anew should be a continual one ---- actually it should be sparked from parents and schools alike during the growing periods of life. Personalities should be attuned to the necessity for curiosity and interest in life and pointed toward active rather than passive activity. Thus, the transition from an active and productive life during the normal working years would be a much simpler process. The "catalyst" for happiness would be "built in".

However, this is not the case at the present time. Our society, until the past decade, has been able to cope with the problems of the older citizens. Mother and Father had been adopted and adapted to the younger families. (The preceding statement is, of course, a generalization as many families enjoy such a situation.) At that time there were always chores for Mother to perform around the house. There were chores for Father. They were busy. Now, in our mechanized living the picture has changed. The modern housewife has dishwashers, washing machines, clothes dryers, etc. None of the menial tasks are left beyond the touch of electricity. Too, homes are smaller and more compact. These are a few of the reasons for change. The human element and the difference between generation, too, is a large factor in happiness for the younger family and for the Senior Citizen. In a situation where two generations are concerned, and this is usually three generations, many emotional factors are involved.

In delving truthfully into my own mind to find reason for my interest in Gerentology I find that one of my reasons is a selfish one ---- preparation for the inevitable within myself. But, from this attitude also stems another which is to help other people to understand and to promote and help others to take an interest. The underlying spark was created in my childhood by my Grandmother who was to all who knew her the epitamy in life after seventy. She lived twenty-six productive years after that age. She had toured the United States thirteen times, some of these by riverboat and covered wagon. She taught kindergarten, school and music and was very active in community affairs. She was a giver ---- of herself ---- which to me is the secret of happiness. Not only is this true in one's younger years and middle aged years, but having developed this spirit is conducive to many continued years of contentment.

Someone once told a joke about a visitor who asked a little boy how old he was. He answered, "That is hard to say, Sir. According to my latest school tests I have a phychological age of 11 and a moral age of 10. But, I suppose, you're referring to my chronological age. That's 8 ---- but nobody pays any attention to that anymore.

This might be true of the younger generation but it is at the age of 65 that statistics are the bitter fact. It needn't be so. This is where the field of Recreation plays so vital a part in the lives of those who are over sixty-five. It is at this time that a person has time to do all of the things that he or she has longed to do all of their lives and the time when life can be rewarded to its fullest with busy and creative lives. It is our duty to light the spark which may or may not lie dormant.

Through the study which has been going on in Montana because of the Governor's Conference on Aging, our citizens have found that Recreation for our Senior Citizens is sadly lacking. It is through this study of a new subject that

Montana looked at itself through the eyes of the Aging. In Cascade County, this problem has been felt and steps have been taken to help. They have organized a 50 Plus Club which began in 1954. It is under the supervision of the Recreation Department and boasts 350 members. Its growth has been fabulous, its members enthusiastic. Mr. Fowell's report is stimulating in the field of Recreation.

Similarly, a project has been started in Silver Bow County. I would like to go into detail on this project as I have been quite close to it. This Club was organized in October of 1959 at the YMCA (by the way, Dr. Shown of Great Falls was a great help.) At that time, there were four who came to the meetings. Now this membership has risen to 71 members and the number is rising every month. The Senior Citizens Club, as it is called elects their own officers which include a President, Vice President, Secretary and Treasurer. They call each of the members for each of their semi-monthly meetings. They have planned and enjoyed field trips and picnics together. The Junior League of Butte sponsored this project and they are helping the club by donating refreshments at each of the meetings. The YMCA has very kindly donated the use of their bowling alleys in the winter time. The Senior Citizens thought that a shuffle board would be a fine addition and so with the help of Mr. Grimm, the YMCA Manager, as to suitable location, it was located on the third floor gym of the YMCA. The men from the club laid the plans and painted the area. The League donated the paint and the shuffle board set. Next year, they have many enthusiastic plans which include cards, lectures on various subjects, such as Social Security, Health, Music and many others. They are, also, interested in skits and drama which they are planning for next year. This Club, as you can see, is obviously still in the beginning stages but the need has proved itself. They are a very interested and united group.

In reading other information which has been brought to my attention, it is the firm belief of medical men that activity is the key to the Senior Citizens'

life. Dr. Maurice Linden, Director of the Division of Mental Health in Philadelphia estimates that people over 65 occupied, in 1959, one-third of the 750,000 mental hospital beds in the United States and that in addition to these 250,000 aged, there are 450,000 in nursing homes and homes for the aged. He reported that the aged number 40 percent of all admissions to mental institutions in 1958, an increase from the 25 percent for the 11 years previously. Dr. Spratt, of Warm Springs, stated, in addressing the Miles City Conference, that here in Montana we are close to the national mean average which in 1960 is 33.5 percent. In hearings before the Senate, Dr. Linden stated that much can be done to help these patients and that there is a special need of volunteer and community services for these patients.

In a paper on Recreation, it was suggested that the older Citizens could do much within the community and feel that they are needed. There are many community services which they could render. For instance - helping to stuff envelopes, helping in the Cancer office, helping to repair toys for the needy children at Christmas and so on. These are but a few of the opportunities within the community. There are few people who volunteer but there are many who are happy to serve if they are but asked.

Further education in the Arts should be presented within communities. These programs should be set up at a time when it is convenient for the older citizen. They should be included, as illustrated in Great Falls, as part of Recreational Programs as a whole which are set up within communities.

Youth of today should be made aware of the vast need as to qualified personnel in this line of work and encouraged to specialize in this field. With proper facilities and with the "spark", which is ever present, the Senior Citizen could find a whole new world in creative productivity and leisure-time happiness.

In closing, I would like to point out that in most of the Conferences held, it was felt that these services should be the outgrowth of programs set up

Recommendations from the

RECREATION COMMITTEE

of

THE MONTANA COMMITTEE ON PROBLEMS OF THE AGING

Basically, is is recommended by the State Recreation Committee on PROBLEMS OF THE AGING that each community be responsible for the needs of its own Senior Citizen. Each community by virtue of its geography and industry has necessarily its own basic statistics which can be satisfied by the communities own personal interest.

These needs could be satisfied by:

1. Senior Citizen Centers

   These may be simple or lavish as the community desires. The main object is to create an atmosphere whereby the Senior Citizen may meet and enjoy people his or her own age and who have common interests and problems. These should be set up with active, reather than passive, activity in mind.

2. Homemaker Services

   These could be set up within the community to help the Senior Citizen who is not able to cope with housekeeping. Other Senior Citizens who are able should be encouraged to do this sort of thing. One of the basic needs of the Senior Citizen seems to be created because of the lack of responsibility. This sort of service is constructive and therapeutic in that the Homemaker is giving and the person receiving is made happier because of a burden being lifted which has been more that he or she could cope with.

3. Encourage the Senior Citizen to take advantage of the opportunities for furthering their education by using the facilities already available within their own community.

4. Encourage Civic Leaders to call upon the Senior Citizen to help with various drives held within the community. Many are willing helpers if but called upon.

5. Encourage Senior Citizens to call upon the sick in nursing homes. Just a visit of a few minutes can brighten the day for many of these patients.

6. Encourage communities to make day camps available for outings for the Senior Citizens. These could possibly be Girl Scout Camps etc. which are generally used for only one month of the year.

within the individual communities themselves, as an overall program would not meet the needs of specific communities. Because of the geographical and diversified industries in Montana, the problems in each community are necessarily different.

As the old age group of today cannot be considered a homogeneous group, so the characterisitics of the aged of the future cannot be considered the same as those of today. There will be a constantly changing picture. As time passes, those who reach 65 will probably have better economic security, health and housing and be better adjusted to retirement living. If we meet our responsibilities now in preparing the aged of the future for satisfying free time activities, we will alleviate many of the leisure-time problems of today's senior citizens. If we do not concern ourselves with the future, the present situation will be with us always.

COMMITTEE ON RECREATION

Mrs. Don McLaughlin

Mrs. Don McLaughlin

REPORT ON MENTAL HEALTH

Emotional difficulties prevade every area of study that the Montana Committee on Problems of the Aging has undertaken. Although mental health, as a specific area, was only referred to infrequently in the six Regional Conferences on the Problems of the Aging, it, nevertheless, is basic to all areas. Since the mental and emotional disturbances are often relatively mild, they are handled by the family physician and so remain under the category of general health. We must, however, consider the total man - his mental and physical being. If, as Dr. Shown has said, "the aged person is made something less than a first-class citizen, then truly

our society is making emtionally crippled persons of our senior citizens."

In the many instances where psychiatric help is needed, we find in Montana rather limited resources for the aging person.

MENTAL HEALTH RESOURCES:

The individual and the manner in which he perceives himself is the first resource. His own interests, aptitudes, strengths and weeknesses must be assessed and utilized effectively. The family, be it a single partner, or a large family constellation, is the next possible resource. We generally expect that all efforts will be expended to solve problems on this level - this includes the local resources, such as, the family physician, social worker, clergyman, public health nurse and other mental health oriented persons, who might be available in a given area.

As the mental and emotional problems increase in severity, the treatment facilities become proportionately less available. There are only a few psychiatrists in private practice in Montana. The cost of prolonged treatment is prohibitive for many retirees, and often the prognosis is not encouraging. Should hospitalization be required, the psychiatric wards in the general hospitals in Montana are not only extremely limited in number, but these sought-after beds are often needed for the more acute (and younger) cases. Few communities have adequate facilities for the care and treatment of the aging psychiatric case and most small communities have no facilities for the person whose illness has progressed to the degree where he cannot remain in the home, the local general hospital or the local nursing home. As the persons' illness reaches the stage of chronicity, the problem increases, since adequate nursing homes are not available.

With inadequate facilities and resources available on the local community level, the tendency is to consider the larger centers. At this point, people begin to look for county or state facilities. The Home for the Aged in Lewistown is looked upon as the answer in many instances where county facilities are inadequate. Here

we see the sick person being removed farther and farther from his family and his home community. There is increasing dependency upon the State to take over the responsibility of the smaller communities.

Montana State Hospital and the Mental Hygiene Clinics, which make up the Department of Mental Hygiene, are overburdened sources. Although Mental Hygiene Clinics are located in four of the larger cities in Montana, the tremendous demands placed upon them by the more acutely ill persons, severely limits the number of patients they can see. Since much of the clinic work is of a counseling and evaluation nature, the facilities for treatment of the aging person are again not complete.

It is unfortunate that the State Hospital must be considered as one of the major resources for the elderly, emotionally upset person. Over 500 persons, or 33.5 percent of the total population of Montana State Hospital, are over 65 years of age. Many of these older individuals could remain in their local communities if there were adequate nursing or rest home facilities.

One of the principle problems that State Psychiatric Hospitals, all over the country have to face, is the lack of adequate facilities. This is only a part of the problem. It is not therapeutically sound to have aging persons, who have spent their productive years in the various communities throughout Montana, who have contributed to and been a part of these communities, suddenly uprooted, taken many many miles from home and placed in a large institution where they are separated from their homes, friends, neighbors and communities. Only a relatively small percentage of these aging patients can be motivated to develop new interests in these strange surroundings. Again, it would seem that facilities on the local community level would be a more adequate answer to the care of the older person with emotional difficulties.

In educating our population to the aging problems, the assistance rendered by the Montana Association for Mental Health, in its attempts to promote mental

health for the aging, should not be overlooked.

It becomes rather apparent that, while Montana does have some limited resources in the area of mental health, they are extremely inadequate, particularly in the local community level.

MENTAL HEALTH NEEDS:

Although few mental health needs were directly referred to in the six Regional Conferences, by implication there were many. It might be true that if all of the problems of general health, employment, housing, rehabilitation, education and recreation were adequately resolved for aging persons, the mental health problem would be less severe. However, this is not reality and to be mentally healthy, we must be realistic. Prevention would be ideal and we must continue to use this positive approach.

As Dr. Shown stated, "we must develop a positive attitude toward aging." Several other physicians have related that aging is a process that begins at birth and continues throughout life. An attitude of rejection on the part of the aging person of himself and his contemporaries, as well as rejection by other age groups in our society, develop feelings of worthlessness that undermine mental health.

The wide range of armaments from positive attitudes to the skill of the geriatrics specialist, have all been expressed as needs for promoting mental health among the aging in Montana. Since it is easier for most persons to think in terms of facilities, perhaps this has been stressed most in the workshops. The need for more adequate nursing home facilities has been mentioned repeatedly. No one can deny this need. However, if more acceptance and affection could be demonstrated toward people in their later years, the need for nursing homes and other larger institutions would be reduced considerably.

Additional mental health counseling services, such as might be available

in psychiatric clinics, are needed. More emphasis on, education to the aging process, is considered a mental health as well as an educational responsibility. Encouraging more mature persons to maintain social contacts, or increase them, as the years go by, the necessity of doing meaningful things and being a contributing member of society, are essential needs for aging persons who are to retain a healthy attitude. It was often indicated that the aging, as well as all other age groups, must have a feeling of being wanted and needed, if life is to have meaning. The personal satisfaction derived from developing interests in later life, rather than losing them, adds much to each person's positive mental health.

These were needs that were repeatedly expressed in the regional conferences. Often they were couched in different terms, but their significance was emphasized by repetition. Participants felt, that constructive changes in any of the areas considered contributed to the mental health of the aging.

RECOMMENDATIONS:

In making a determined effort to maintain an adequate degree of mental health among our aging population, it is imperative that our society, starting with the basic unit of the family, endeavor to instill in the present and future generations, affection, acceptance and understanding of their elders. It is further necessary that we provide meaningful roles and opportunities for the aging, thereby, giving them the earned right to retain their position as first-class citizens.

More specifically, the recommendations that have come from the six Regional Conferences are:

1. That each person, with his particular problems be considered as an individual; who to be mentally healthy, must retain his identity.
2. Serious efforts be made to first care for the demonstrated needs on the local level.

COPY

Aug. 26, 1960

Dr. William T. Van Orman,
Regional Representative
Program on Aging, Room 551
621 - 17th Street
Denver 2, Colorado

Dear Dr. Van Orman:

Since we feel that by becoming too agency specific we run the risk of releasing individual responsibility, this review will contain little reference to special agencies or departments. However, we do feel that the level of implementation has been indicated.

In reference to the six recommendations made by the Montana Committe for Problems of the Aging in the area of Mental Health, it was hoped that much would be accomplished by the individuals or the family units themselves. Where the severity of the problem requires assistance, that is not available within the family unit, professional workers, either as private practitioners or as agency representatives, must be called upon.

The word local was used to indicate the most immediate geographical unit that might have already existing facilities or have the untapped potential for providing the needed services. In the third recommendation, the reference was to the utilization of interested persons or agencies already existing in the community to provide the counseling. These would be interested or informed lay persons who might make up a board or service to assist the aging. Professional workers in allied fields might do this as a special project or it could be the city, county, state or federal agencies who already have designated responsibilities in this area.

Recommendations	Level of Implementation
1. Each person, with his particular problems, be considered as an individual.	1. Family first concerned, although the individual approach should always be retained regardless of level of assistance.
2. Efforts be made to first care for demonstrated needs on local level.	2. Attempt to care for the needs beginning with the smallest geographical and governmental units; neighborhood, town, city, county. Utilization of professionals, such as physicians, clergymen and other private resources.
3. More effective utilization be made of local resources for counseling.	3. Essentially same as 2. Emphasis again on private resources or town, city, county supported facilities.

4. That more professional mental health counseling services be made available.

4. This should be carried out in the following order: private psychiatrists, local community supported mental health or guidance clinics, State Mental Hygiene Clinics of the State Department of Mental Hygiene.

5. More adequate local nursing and rest home facilities be available.

5. These facilities be provided by private operators, by church or service groups, by the city, county or other appropriate community of a relatively small geographic area.

6. Every effort be made to see that the older person not be isolated, but that he maintain contacts with other persons.

6. These efforts would be made by the family, the neighborhood, church, local service clubs, community organizations made up of aged persons themselves. In this area professional workers should only act in an advisory capacity.

It is significant that, throughout the work of the Montana Committee on Problems of the Aging, including the six regional conferences, there has been relatively little reference to implementation of program by State or Federal agencies. In the area of mental health there were no case where the feeling was expressed that there was a need for Federal level assistance. Only in one instance was it felt necessary to call for State level agency assistance. Most problems could be resolved from the county level downward to the smallest possible functioning governmental unit and on to the individual himself.

Dr. Spratt and I have discussed this subject and he concurs with this report.

Very truly yours,

Louis W. Wurl, OTR

LWW/mlm

cc: Ralph C. Knoblock
Francis A. Howard

COPY

3. More effective utilization be made of local resource persons for counseling.

4. That more professional mental health counseling services be made available.

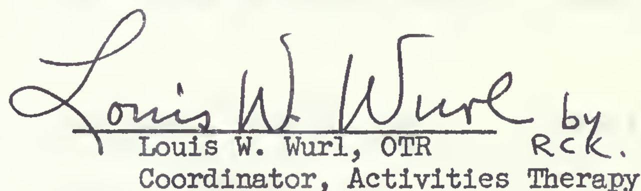
5. More adequate local nursing and rest home facilities be available so the emotionally disturbed, aged person can remain in, or as close to his home community as possible, despite his need for institutionalization.

6. Every effort be made to see that the older person should not be isolated, but that he maintain contacts with other persons.

These recommendations, pertaining to the area of mental health, must be given serious consideration in attempting to resolve some of the basic problems of the aging in Montana.

It is hoped, that some of the information that has been brought to the attention of those interested in aging will lead to better mental health for everyone.

COMMITTEE ON MENTAL HEALTH



Louis W. Wurl, OTR
Coordinator, Activities Therapy

Resources: There are 2477 beds available to Montana's aged citizens in public and private facilities within the state. This figure includes the State Home at Lewistown and the Old Soldiers' Home at Colombia Falls.

There are 496 beds in the planning or proposal stage, as estimated by the Montana State Health Department.

Needs: According to the 1960 census there are 63,602 people sixty-five years of age and older in the state of Montana.

The Department of Health, Education and Welfare estimates that 9.7 percent of persons over sixty-five years of age are in need of instutional care.

Applying this percentage to the Montana population, we arrive at the figure of 6169 aged people in need of nursing or domiciliary care.

Subtracting the available beds from the total needing care, a deficiency of 3792 beds is indicated. Assuming that the 496 proposed beds materializes, there remains a deficiency of 3296 beds.

The above estimates are made without regard to the quality of existing facilities, many of which are sub-standard and incapable of qualifying for licensure under the new Montana regulations. Your committee therefor regards the figure 3296 as a minumum.

The various county committees have determined that the need for housing and nursing facilities is acute in 83 percent of the counties of Montana.

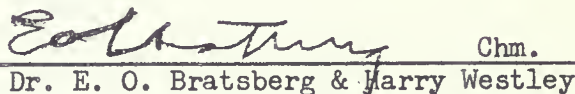
Specific Reccommendations: The Sub-Committee on Housing of the Montana Committee on Problems of the Aging concurs with the findings and recommendations of the six Regional Conferences on Aging held throughout the state during the spring of 1960, as follows: housing of the community's aged citizens is a local responsibility which can best be met on the community level. Only six percent of the county committees recommend federal financial assistance in providing facilities for the aged.

Your committee favors the development of community centered domiciliary and nursing facilities where the aged can be cared for in thier home communities near their relatives and friends. We feel that such facilities should be kept as small as is consistent with economical operation to foster a homelike atmosphere rather than an institutional atmosphere.

Each community should determine whether its needs can best be met by community-owned facilities, proprietary facilities, or church and charitable sponsored facilities, or by a combination of the above.

Your committee wishes to commend the Montana State Health Department for its new regulations for the construction and operation of domiciliary and nursing facilities for the aged. We believe these regulations will materially improve the quality of care afforded our aged people, but we recognize that the application of higher standards will result in considerably higher cost to the operators. We believe that the application of the new and higher standards should be accompanied by increased public assistance to aged individuals so that they may avail themselves of the more acceptable levels of care contemplated by the new regulations.

Sub-Committee on Housing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Dr. E. O. Bratsberg & Harry Westley

SUB-COMMITTEE REPORT ON EDUCATION FOR AGING

"As a Nation, we are beginning to realize that for the well-being, strength, and happiness of society and the individual, it is essential that older people remain an active part of their families and their communities. It is important, also, for the individual's own sense of worth and importance. In order to accomplish this broad objective, many older people need new knowledge, attitudes and skills. While it is often possible to document the cost of illness or unemployment, it is difficult to document the cost of ignorance. All people, young and old alike, need to know more about aging. <u>In general, very little has been done in comparison with the needs that exist</u>." (White House Conference on Aging Background Paper on Education for Aging, p. 145.)

Montana's Facilities and Services

"Very little is being done" in the area of "Education for Aging" was the typical report when the various county subcommittees made their reports to the six Regional Conferences. There was an occasional mention of a Golden Age Club or a class in one of the "crafts"; but, even here the reference was usually to recreation rather than education. Not a single formal program designed to serve "Education for Aging" was mentioned.

Needs

Three educational tasks present themselves:

1. To change the attitude of our total population toward older people.
2. To develop appropriate expectations and behavior in all aging persons.
3. To retain older persons for social usefulness in line with their changing capabilities.

What are the problems in regard to the developmental tasks of aging people? Problems of changing family relationships, of community status, of financial security, of employment, of rehabilitation, and of housing and living arrangements, of health, of leisure activities, and religious feelings are among the

main ones. Education has an important role to play in helping people solve these problems, and helping them make the necessary adjustment. Old people themselves must solve their problems. Only they, working through the educative process, can arrive at the necessary changes. Many community agencies besides the schools, however, have resources to offer. Recreation department, library, employment and rehabilitation offices, family service agencies, housing groups, churches, nursing services, convalescent homes and homes for the aging, as well as others, have facilities that could be utilized. An adult education program has a great deal to offer. One of its functions is that of providing the educational ingredients in the activites of other agencies. Possibly the most important role of the school, which it shares with a few other agencies, is to stimulate the formation of groups and councils of aging people who are concerned about their own problems. The assignment of a sympathetic counselor to work with groups of older residents is probably the first and best step. Such a counselor can advise, help discover resource, interpret the needs and potentials of the school, and help promote educational activities desired by the elderly. Such a counselor is a friend in court, so to speak, who opens channels of communication with all organizations and agencies and programs having educational services to offer. Golden Age Clubs, and other groups, can turn to the counselor for advice in approaching their problems through the educational program. (Submitted by Ted Barkhurst, Administrative Assistant to Great Falls Public Schools, for Cascade County.)

Nearly every county mentioned some aspect of the needs so well summarized by Ted Barkhurst above. A few examples follow:

Daniels County:

"2. Need for more education regarding available facilities and services."

"5. Need educational direction for teaching the elderly new talents, to include hobbies, etc."

"6. Education from the standpoint of health in the Aging is needed."

Roosevelt County:

"Community has little or no provision to teach new skills or hobbies, or to improve old skills."

Rosebud County:

"2. Education regarding problems of the aging beginning at age 45."

"3. Rehabilitation program aimed at re-training those over 45, if needed."

Musselshell County:

"Educational preparation for retirement; self-improvement and/or self-development, the latter to include the development of cultural interests and personal health care; better understanding of self--to include adjustments for retirement; opportunity for older people to occupy themselves along vocational lines, arts, crafts, and hobbies."

Dr. Winter, at Miles City (quoting A.M.A.):

"1. Stimulation of a realistic attitude toward aging by all people."

Dr. Elting, at Miles City (Custer County Committee):

"1. Help the families of aging citizens and the communities as a whole understand the problems of aging."

Dr. Shown at Glasgow:

"It is not sufficient that we add years to the life of the individual; we also must add life to these years."

Recommendations

Most county reports seemed to imply, or stated, that the various individual communities now have little or no programs, or plans, for Education for Aging, but could carry on their own programs if adequate information, suggestions, directions, and types or patterns of successful activities and programs were available to the lay-volunteer community leaders.

The reports make it quite clear that the average community does not have the professional personnel necessary to do its own research and design its own teaching aids and guide-lines for an effective program for the Education for Aging.

October 3, 1960

Dr. William T. Van Orman
Department of Health, Education
and Welfare
621 - 17th Street
Denver, Colorado

My dear Dr. Van Orman:

Dr. F. A. Howard has informed me that you desire more information regarding the different sections of the Montana Report for Problems of the Aging.

I think the recommendations for the Subcommittee on Education stated in the report, pp. 63-64, a fairly complete description of the general procedure to be followed and the goals to be reached.

I do not feel that I or any other member of the Montana Committee have sufficient information to go much more into detail regarding the description of procedures. It could be argued that this project should be handled by the Department of Health, or it might be argued, by the Office of Education. On the other hand, some would argue that it should be handled by the Department of Welfare. It is not clearly a case of rehabilitation. Therefore, it would be my presumption that if the recommendations were acceptable, a committee composed of some member, level, or division of the U. S. Office of Education, a member from the Welfare Department, and possibly one from its rehabilitation branch should make general plans. The determination of the specific agency to carry out such a project is probably an administrative matter rather than an educational or welfare program. I am not in a position to know which specific branch of the department could best do the job.

After the Whitehouse Conference has made its specific recommendations, I would presume that this set of recommendations in the Montana Report, pp. 63-64, might be much modified and possibly narrowed so that the actual assigning of it to a specific branch or agency would be much simplified.

Beyond this, I doubt that further remarks would clarify anything since rather specific instructions regarding goals to be reached and procedures to be followed are included in the recommendations.

Very truly yours,

E. A. Atkinson
Director
Summer Session & Extension

EAA:jt
cc: Mr. Ralph C. Knoblock, Mr. Francis A. Howard

Therefore, we make the following recommendations:

1. That the United States Department of Health, Education, and Welfare be requested to plan, write, and print a manual, or set of manuals, on the subject of Education for Aging. The manual, or manuals, should be designed to assist local volunteer community leaders in planning and carrying out a program of Education for Aging in a single community. It should include information, outlines, bibliographies, methods of procedure, teaching aids, general suggestions and such other related material as the Department of Health Education and Welfare deems helpful.

The manual, or manuals, should be designed to assist a local volunteer leader, or teacher, in giving a formal course; leading a single, or series of group discussions or study groups; giving a single or series of lectures; or of planning a total community program.

2. That the manual, or manuals, referred to in "1" above shall be distributed free, or sold at cost, to any American Citizen upon request.

3. That at least one copy of the manual, or manuals, on Education for Aging be deposited in every branch, local or field office of every branch, division, bureau, or service of the Department of Health, Education and Welfare.

Dr. E. A. Atkinson, Chairman

STATISTICS AND DATA USED IN MONTANA

NUMBER OF PERSONS 65 AND OVER AND PERCENTAGE OF TOTAL STATE POPULATION, 1957

State	Number	Percentage
Alabama	237,000	7.6%
Arizona	72,000	6.8
Arkansas	185,000	10.5
California	1,152,000	8.5
Colorado	139,000	8.5
Connecticut	212,000	9.4
Delaware	31,000	7.3
Florida	418,000	10.2
Georgia	264,000	7.1
Idaho	55,000	8.5
Illinois	904,000	9.4
Indiana	408,000	9.1
Iowa	312,000	11.2
Kansas	222,000	10.8
Kentucky	270,000	9.0
Louisiana	209,000	6.9
Maine	101,000	10.9
Maryland	194,000	6.9
Massachusetts	511,000	10.7
Michigan	570,000	7.4
Minnesota	327,000	9.9
Mississippi	175,000	8.1
Missouri	455,000	10.8
Montana	62,000	9.4
Nebraska	151,000	10.6
Nevada	13,000	5.1
New Hampshire	63,000	11.0
New Jersey	479,000	8.6
New Mexico	47,000	6.0
New York	1,496,000	4.5
North Carolina	282,000	6.4
North Dakota	54,000	8.4
Ohio	820,000	8.9
Oklahoma	230,000	10.3
Oregon	163,000	9.4
Pennsylvania	1,025,000	9.3
Rhode Island	81,000	9.8
South Carolina	144,000	6.2
South Dakota	67,000	9.8
Tennessee	274,000	8.0
Texas	651,000	7.2
Utah	53,000	6.4
Vermont	43,000	11.6
Virginia	255,000	7.0
Washington	250,000	9.4
West Virginia	164,000	8.3
Wisconsin	372,000	9.6
Wyoming	24,000	7.7
District of Columbia	66,000	8.3
United States	14,612,000	8.7%

Source: U. S. Bureau of the Census. As reported in "The Aged and Aging in the United States; A National Problem," a Report by the Subcommittee on Problems of the Aged and Aging, U. S. Senate, 1960.

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

TOTAL POPULATION OF THE STATE

Census of 1950	590,966
Estimate of Population 1958	688,000
Percentage Increase 1950-1958	16.4%

TOTAL 65 YEARS AND OLDER

Census of 1950	50,864
Estimate July 1959	65,000
Percentage Increase 1950-1959	27.8%
Percent of Population 1950	8.6%
Percent of Population 1959	9.4%

PERSONS 65 YEARS AND OLDER RECEIVING PUBLIC FINANCIAL ASSISTANCE

Number Receiving Old Age Assistance November 1959	7,107
Number Receiving Old Age & Survivors Insurance February 1959	41,047
Number Receiving Both OAA & OASI March 1959	2,191
Number in State Hospital, Warm Springs November 1959	518
Number in Special Care Facilities, Nursing Homes, etc.	926
Number in Home for the Aged, Lewistown	105
Number in Old Soldiers Home, Columbia Falls (capacity 100) Men	79
Women	16
Number Receiving Unemployment Insurance December 1959	4,378
Ages 45 to 64	4,023
Over 65	355

EMPLOYMENT OF OLDER WORKERS (Age 45 and Older)

Number Seeking Work Through the State Employment Service November 1959	5,699
Ages 45 to 64	5,232
Female	1,111
Over 65	467
Female	96
Number Filing New York Applications with the Employment Service, July-December 1959	4,967
Over 65	371
Number Placed on Jobs by the Employment Service July-December 1959	4,058
Over 65	147

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

Number of Old Age Assistance Recipients in Special Care Facilities, by County, October 1959

Note: Recepients in special care facilities are those in hospitals, nursing homes and boarding homes whose grants are subject to the $85 maximum.

County	No. Of OAA Recipients October 1959	Recipients in special care facilities	
		Number	% of total
TOTAL.........	7,145	926	13%
Beaverhead............	115	15	13
Big Horn..............	138	6	4
Blaine................	139	23	17
Broadwater............	32	8	25
Carbon................	185	5	3
Carter................	64	12	19
Cascade...............	581	103	18
Chouteau..............	55	13	24
Custer................	187	40	21
Daniels...............	39	5	13
Dawson................	94	18	19
Deer Lodge............	88	17	19
Fallon................	46	2	4
Fergus................	222	32	14
Flathead..............	387	41	11
Gallatin..............	191	23	12
Garfield..............	27	11	41
Glacier...............	147	4	3
Golden Valley.........	21	3	14
Granite...............	35	3	9
Hill..................	151	20	13
Jefferson.............	46	6	13
Judith Basin..........	61	7	11
Lake..................	198	33	17
Lewis & Clark.........	232	7	3
Liberty...............	9	1	11
Lincoln...............	137	6	4
Madison...............	131	10	8
McCone................	34	2	6
Meagher...............	51	10	20
Mineral...............	43	11	26
Missoula..............	354	70	20

(Continued)

County	No. of OAA recipients October 1959	Recipients in special care facilities	
		Number	% of total
TOTAL.........	7,145	926	13%
Musselshell...........	81	17	21
Park..................	147	24	16
Petroleum.............	12	4	33
Phillips..............	107	8	7
Pondera...............	71	13	18
Powder River..........	26	5	19
Powell................	81	5	6
Prairie...............	40	2	5
Ravalli...............	233	14	6
Richland..............	140	11	8
Roosevelt.............	129	12	9
Rosebud...............	130	24	18
Sanders...............	148	18	12
Sheridan..............	75	4	5
Silver Bow............	538	62	12
Still Water...........	67	10	15
Sweet Grass...........	58	11	19
Teton.................	67	18	27
Toole.................	50	19	38
Treasure..............	19	1	5
Valley................	123	14	11
Wheatland.......	47	13	28
Wibaux................	26	3	12
Yellowstone...........	490	47	10

MONTANA COMMITTEE ON THE PROBLEMS OF THE AGING

STATE HOSPITAL SURVEY

As a part of the research and study undertaken by the Montana Committee on the problems of the Aging, the committee enlisted the cooperation of the Montana Hospital Association through the mailing of a questionnaire intended to determine the number of individuals age 65 or over who were hospital confined during a given week.

The statistics which were accumulated through this survey appear below. These statistics are based on a specific day during the month of February, 1960, on which the hospitals in question completed the questionnaire furnished to them.

Number of Hospitals Reporting	42
Number of patients in the hospital on a given day (excluding newborn)	1733
Number of patients in the hospital on a given day over age 65	576
Number of male patients over age 65	301
Number of female patients over 65	304
Number of widows or widowers over 65	276
Number of patients over 65 hospitalized for more than 30 days	181
Number of patients over 65 hospitalized for acute illnesses	283
Number of patients over 65 hospitalized for chronic illnesses	240
Number of patients over 65 who are recipients of public assistance	151
Number of patients over 65 not recipients of public assistance considered poor or doubtful credit risks	66
Number of persons over 65 having a recognized and satisfactory type of health insurance	188
Number of patients over 65 who could have just as easily been taken care of in a nursing home	103

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

County	1950 Population (Census)	Estimated Population 1958	Percentage Increase 1950-1958	65 & Older 1950 Census	Estimated 65 & Older 1959
Silver Bow	48422	53000	.94	4418	5584
Deer Lodge	16553	20600	2.44	1785	2321
Granite	2773	3200	1.54	254	325
Beaverhead	6671	7500	1.24	562	841
Jefferson	4014	4100	.21	390	486
Madison	5998	5400	.99	711	865
Gallatin	21902	26200	1.96	1751	2256
Lewis & Clark	24540	29600	2.06	2225	2873
Broadwater	2922	2600	-1.10	265	322
S½ Powell	5001	6300	2.60	430	560

County	Percentage Increase 1950-1959	OAA Recipient Nov. 1959	OASI over 65 Beneficiaries Feb. 1959	Receiving Both OAA & OASI March 1959
Silver Bow	2.64	534	3779	172
Deer Lodge	3.00	87	965	25
Granite	2.79	35	202	16
Beaverhead	2.70	114	463	37
Jefferson	2.46	44	294	12
Madison	2.17	130	471	36
Gallatin	2.88	195	1523	62
Lewis & Clark	2.91	234	1865	89
Broadwater	2.15	32	205	15
S½ Powell	3.02			

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

County	1950 Population Census	Estimated Population 1958	Percentage Increase 1950-1958	65 & Older 1950 Census	Estimated 65 & Older 1959
Cascade	53027	73100	3.79	4210	5610
Judith Basin	3200	3000	.62	341	418
Meagher	2079	2800	3.47	231	306
Chouteau	6974	7600	.90	647	817
Hill	14285	18000	2.60	1049	1368
Liberty	2180	2600	1.93	148	191
Teton	7232	7600	.51	515	645
Toole	6867	8100	1.80	498	640
Pondera	6392	7100	1.11	431	547
Glacier	9645	11100	1.51	541	691

County	Percentage Increase 1950-1959	OAA Recipients Nov. 1959	over OASI 65 Beneficiaries February 1959	Receiving Both OAA & OASI March 1959
Cascade	3.33	572	3586	244
Judith Basin	2.26	61	177	8
Meagher	3.25	53	170	17
Chouteau	2.63	53	437	9
Hill	3.04	148	727	42
Liberty	2.91	9	92	1
Teton	2.52	66	463	18
Toole	2.85	52	390	17
Pondera	2.69	71	364	15
Glacier	2.77	143	327	34

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

County	1950 Population (Census)	Estimated Population 1958	Percentage Increase 1950--1958	65 and Older 1950 Census	Estimated 65 and Older 1959
Yellowstone	55875	77600	3.89	3892	5196
Big Horn	9824	10000	.18	640	797
Treasure	1402	1800	2.84	109	143
Musselshell	5408	5100	.57	643	789
Golden Valley	1337	1400	.47	149	187
Fergus	14015	13700	.22	1494	1846
Petroleum	1026	800	2.20	90	107
Wheatland	3187	3100	.27	306	378
Carbon	10241	[illegible]100	1.11	1073	1303
Stillwater	5416	5800	.71	528	665
Sweet Grass	3621	3800	.49	358	449
Park	11999	13600	1.33	1158	1474

County	Percentage Increase 1950--1959	OAA Recipients Nov. 1959	OASI over 65 Beneficiaries Feb. 1959	Receiving Both OAA and OASI March 1959
Yellowstone	3.35	485	3699	163
Big Horn	2.45	139	408	31
Treasure	3.12	19	82	2
Musselshell	2.27	82	500	30
Golden Valley	2.55	20	108	4
Fergus	2.36	219	1167	66
Petroleum	1.89	11	69	1
Wheatland	2.35	47	232	18
Carbon	2.14	183	896	42
Stillwater	2.59	67	442	17
Sweet Grass	2.54	58	298	22
Park	2.73	146	807	54

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

County	1950 Population Census	Estimated Population 1958	Percentage Increase 1950-1958	65 and older 1950 Census	Estimated 65 & Older 1959
Missoula	35493	45400	2.79	2993	3916
Ravalli	13101	13400	.23	1420	1770
Mineral	2081	2700	2.97	224	294
Sanders	6983	7500	.74	516	977
Lake	13835	12900	.68	1385	1696
Flathead	31495	34700	1.02	2747	3477
Lincoln	8693	11000	.79	713	931
N½ Powell	1300	1500	1.54	154	198

County	Percentage Increase 1950-1959	OAA Recipient Nov. 1959	OASI over 65 Beneficiaries Feb. 1959	Receiving Both OAA & OASI March 1959
Missoula	3.08	358	2620	119
Ravalli	2.46	234	1237	65
Mineral	3.12	42	131	11
Sanders	8.93	148	617	59
Lake	2.25	198	1092	67
Flathead	2.66	382	2491	138
Lincoln	3.06	134	601	40
N½ Powell	2.86			

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

County	1950 Population (Census)	Estimated Population 1958	Percentage Increase 1950--1958	65 and Older 1950 Census	Estimated 65 and Older 1959
Custer	12661	14000	1.06	1163	1473
Rosebud	6570	6900	.50	516	647
Powder River	2693	2500	.72	210	257
Carter	2798	2500	1.07	252	306
Fallon	3660	4200	1.48	288	368
Wibaux	1907	1500	2.13	151	180
Richland	10366	11300	.90	834	1053
Prairie	2377	2700	1.36	230	293
McCone	3258	3400	.44	241	302
Dawson	9092	12800	4.08	699	936
Garfield	2172	2400	1.05	191	242

County	Percentage Increase 1950--1959	OAA Recipients Nov. 1959	OASI over 65 Beneficiaries Feb. 1959	Receiving Both OAA and OASI March 1959
Custer	2.67	185	834	56
Rosebud	2.54	130	332	26
Powder River	2.24	24	123	4
Carter	2.14	63	133	16
Fallon	2.78	47	211	4
Wibaux	1.92	27	137	5
Richland	2.63	138	713	48
Prairie	2.74	41	131	7
McCone	2.53	32	149	4
Dawson	3.39	94	519	30
Garfield	2.67	27	134	4

MONTANA COMMITTEE ON
THE PROBLEMS OF THE AGING

County	1950 Population (Census)	Estimated Population 1958	Percentage Increase 1950-1958	65 and older 1950 Census	Estimated 65 and Older 1959
Valley	11353	14000	2.33	832	1079
Phillips	6334	6200	- .21	620	766
Blaine	8516	7100	-1.66	726	872
Daniels	3946	3900	- .12	256	317
Sheridan	6674	6800	.19	589	734
Roosevelt	9580	11400	1.88	712	916

County	Percentage Increase 1950--1959	OAA Recipient Nov. 1959	OASI over 65 Beneficiaries Feb. 1959	Receiving Both OAA & OASI March 1959
Valley	2.97	122	694	38
Phillips	2.35	108	495	27
Blaine	2.01	139	408	31
Daniels	2.38	39	311	10
Sheridan	2.46	74	556	11
Roosevelt	2.87	130	673	29

TRANSCRIPT OF REGIONAL CONFERENCES